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Canada Health Act

Annual Report 2000-2001

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Rapport annuel de 2000-2001 sur l'application de la Loi canadienne sur la santé

Prepared by:

Health Canada
Health Policy and Communications
Canada Health Act Division

To contact the Canada Health Act Division:

Visit our website at: http://www.hc-sc.gc.ca/medicare

E-mail us at: medicare_hc@hc-sc.gc.ca

Write to us at:

Canada Health Act Division
0908C1 Brooke Claxton Building
Tunney's Pasture
Ottawa, Canada
K1A 0K9

For additional copies of this publication, please contact the Health Canada Publications Centre at the following coordinates:

Health Canada Publications Centre
0900C2 Tunney's Pasture
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K1A 0K9

Telephone: (613) 954-5995
Fax: (613) 941-5366
E-mail: info@hc-sc.gc.ca

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Minister of Health Ministre de la Santé

The Honourable/L'honorable A. Anne McLellan

Ottawa, Canada K1A 0K9

Her Excellency, the Right Honourable Adrienne Clarkson, Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year ended March 31, 2001.

A. Anne McLellan

Canada

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Health Canada would like to acknowledge the work and effort that went into producing this Annual Report. It is through the dedication and timely commitment of the following departments of health and their staff that we bring you this report on the administration and operation of the *Canada Health Act*:

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Prince Edward Island Health and Social Services

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

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Manitoba Health

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British Columbia Ministry of Health Services
British Columbia Ministry of Health Planning

Yukon Department of Health and Social Services

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Introduction

The five principles of the *Canada Health Act* are the cornerstone of the Canadian health care system, and have iconic status for Canadians. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* provides the provinces and territories with criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

This report is produced in accordance with the requirement set out in section 23 of the *Canada Health Act:*

> "The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed."

Under the *Canada Health Act*, provinces and territories are required to provide information on the operation of their health care plans as they relate to the criteria and conditions of the Act. The approach to this information gathering has been collaborative, where provinces, territories and the federal government have worked together to supply the information needed by the Minister to fulfill his responsibilities.

Chapter 1 provides an overview of the *Canada Health Act* and information concerning its administration, interpretation, compliance and deductions made in 2000-2001. Chapter 2 presents descriptions of the provincial and territorial health insurance plans related to programs and services that came under the scope of the *Canada Health Act* for the year ending March 31, 2001. Six annexes, listed below, are also appended to this report, providing an array of additional information relevant to the administration of the Act and its place in the Canadian health care system.

Statistical data on insured hospital, physician and surgical dental health care services in each province and territory are detailed in Annex A. A copy of the *Canada Health Act* and its regulations (unofficial consolidation to June 2001) is available in Annex B. Annex C provides copies of the two key policy statements that clarify the federal interpretation of the criteria and conditions of the *Canada Health Act*. Annex D summarizes the deductions and refunds from federal transfers under the provisions of the Act. Annex E describes the evolution of federal transfers for health care in Canada. Annex F provides a glossary of terminology used in this report. Inside the back cover you will find contact information for provincial and territorial departments of health.

Chapter 1 – Canada Health Act: Overview, Administration, Interpretation, Compliance and Deductions

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

(Justice Emmett M. Hall)

Overview

The Canada Health Act

What is it?

The *Canada Health Act* is Canada's federal health insurance legislation.

The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

The *Canada Health Act* establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service for such services.

What is Covered?

There are two categories of service defined in the *Canada Health Act*:

- insured health care services, and
- extended health care services.

Insured health care services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in- and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and x-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the *Canada Health Act* are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Who is Covered?

Insured persons are eligible residents of a province or territory. A resident is defined in the *Canada Health Act* in relation to a province as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons not covered by the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Requirements of the Canada Health Act

The *Canada Health Act* contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

- five program criteria that apply only to insured health care services;
- two conditions that apply to insured health care services and extended health care services; and
- extra-billing and user charge provisions that apply only to insured health care services.

The Criteria

1. **Public Administration**

   This criterion applies to the health care insurance plans of the provinces and territories, not to hospitals or other facilities providing hospital care. The health care insurance plans are to be administered and operated on a non-profit basis by a public authority. The public authority must be accountable to the provincial and territorial governments and subject to audits of its accounts and financial transactions.

2. **Comprehensiveness**

   The health care insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners.

3. **Universality**

   All insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

   Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health care services.

4. **Portability**

   Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" jurisdiction during any minimum waiting period, not to exceed three months, imposed by the new province or territory of residence. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

   Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

   The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to permit one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

   If insured persons are temporarily absent in another province or territory, insured services are to be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

   Prior approval by the health care insurance plan may also be required before coverage is extended for elective (non-emergency)

services to a resident while temporarily absent from the home province or territory.

5. Accessibility

The health care insurance plans of the provinces and territories must provide:

- reasonable access to insured health care services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances). Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
- reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- payment to hospitals to cover the cost of insured health care services.

The Conditions

Information — the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

Recognition — the provincial and territorial governments are to recognize appropriately the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

Extra-billing — this occurs if a physician or dentist directly charges an insured person for an insured service that is in addition to the amount that would normally be paid for by the provincial or territorial health insurance plan. For example, if a physician were to charge patients five dollars for an office visit that is insured by a health insurance plan, the five-dollar charge would be extra-billing.

User charges — these are direct charges to patients, other than extra-billing, for insured services of a province's health insurance plan that are not payable, directly or indirectly, by the health insurance plan. For example, if patients were charged a fee before being provided treatment at a hospital emergency department, the fee would be considered a user charge.

Other Elements of the Act

Regulations

The Governor in Council may make regulations for the administration of the *Canada Health Act* and for putting its purposes and provisions into effect.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (For a copy of these regulations, please see Annex B).

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments. For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary Penalty Provisions

Breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction is based on the gravity of the default.

The *Canada Health Act* stipulates a consultation process with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have never been applied.

Health Care Services not Covered by the Act

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services may include home care, pharmacare, ambulance services, optometric services and dental services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children or seniors), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court, and cosmetic services.

Health care services covered by provincial workers' compensation legislation are outside the scope of the *Canada Health Act*.

Administration

The Canada Health Act Division

The Division, part of the Intergovernmental Affairs Directorate, Health Policy and Communications Branch, Health Canada, administers the *Canada Health Act*. It provides policy advice related to the *Canada Health Act*, monitors a broad range of sources to assess provincial and territorial compliance with the criteria and conditions of the Act, informs the Minister of possible non-compliance with the Act and recommends appropriate action. The Division also develops interpretations under the Act, provides support to legal counsel in court cases in which the *Canada Health Act* is involved, and maintains a centre of expertise on the Canadian health insurance system.

The Division works in conjunction with Health Canada's regional offices to obtain information about developing issues, new directions, and policies in provinces and territories that may be needed for administration of the Act. A funding increase of $4 million per year announced in May 2000 by the Minister of Health, in response to recommendations made by the Auditor General in 1999, resulted in increased staff at headquarters and in the regions, and strengthened Health Canada's policy analysis and reporting capacity vis-à-vis the *Canada Health Act*.

Another strategic initiative to provide the Minister with better information in a timely manner is the development of a more systematic method of intelligence gathering, storage and retrieval. Health Canada staff at headquarters and in the regions contribute to the Canada Health Act Information System by reviewing, analyzing and cataloguing information relevant to the administration of the Act and the provision of health care in Canada.

The Division responds to enquiries about the Act and health insurance issues received by telephone, mail and the Internet, from the public, Members of Parliament, government departments, stakeholder organizations and the media. During 2000-2001, the Division responded to more than 2,000 such enquiries. Media relations staff within the Branch also responded to approximately 350 media enquiries related to the *Canada Health Act*.

The Division compiles information for dissemination to the provinces and territories through the Additional Benefits Information System. This information relates to services outside the scope of the *Canada Health Act*, which the provinces and territories provide to their residents at their discretion, and on their own terms and conditions.

The Division also makes information concerning the Act and other health insurance topics available via its Internet site, www.hc-sc.gc.ca/medicare. In 2000-2001, our web site received an average of 4,729 visits per week. This means that a page from our site is referred to, on average, every two minutes.

The Division is also involved in the following activities.

Coordinating Committee on Reciprocal Billing

The Canada Health Act Division chairs the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing (CCRB) and acts as a secretariat for the Committee.

The Committee was formed in 1991 to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory, when travelling, or during educational leave or temporary employment. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. These agreements are interprovincial/territorial, not federal, and signing them is not a requirement of the *Canada Health Act*.

A federal/provincial/territorial working group mandated by the CCRB reviews, updates, and provides administrative clarifications to an interprovincial/territorial agreement on eligibility and portability. This agreement sets minimum standards with respect to interprovincial/territorial eligibility and portability of health insurance programs.

Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Diagnostic Services

The growth in the use of Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services in recent years is illustrative of the emergence and adaptation of health care technologies, which are part of the ongoing evolution of Canada's health care system. These services have been embraced by both public and private providers as part of a modern and responsive health care system, which brings many challenges for governments, health care providers and the public in terms of managing costs and establishing and understanding guidelines for access to and availability of these services.

To gain a better understanding of these issues, the Federal/Provincial/Territorial Working Group on Supply, Demand and Delivery of MRI and CT Services in Canada was formed in the summer of 2000 to review the provision and delivery of MRI and CT services within Canada's health care system. All provinces and territories named members to the Working Group (Quebec's representative participated as an observer). The Working Group also examined options to prevent insured persons from paying or being charged for medically necessary high-technology diagnostic services, as such incidents had been brought to the attention of the federal Minister of Health and are a concern under the *Canada Health Act*.

The mandate of the Working Group was two-fold: first, to document the supply, demand and delivery of MRI and CT diagnostic services in all jurisdictions of Canada in order to provide a "situation report" on how these services are provided to Canadians; and second, to provide

recommendations to the Conference of Federal/Provincial/Territorial Deputy Ministers of Health on how to ensure appropriate and timely access, on uniform terms and conditions, to these diagnostic services through the publicly funded health care system.

Dispute Avoidance and Resolution

On September 10, 2000, the Honourable Allan Rock, federal Minister of Health, wrote to the Honourable Gary Mar, Minister of Health and Wellness for Alberta, to indicate the federal government's willingness to initiate a collaborative process among health ministries to develop a *Canada Health Act* dispute avoidance and resolution mechanism, consistent with commitments in the Social Union Framework Agreement (SUFA) and the federal government's obligations under the Act.

In October 2000, the Conference of Federal/Provincial/Territorial Ministers of Health agreed to create a federal/provincial/territorial working group to undertake this work, with Health Canada and Alberta as co-chairs. Other members of the working group include Saskatchewan, Ontario and Newfoundland and Labrador.

Interpretation, Compliance and Deductions

Interpretation

Epp Letter

Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp letter (see Annex C) remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

At the Federal/Provincial/Territorial Health Ministers' Meeting of September 1994 in Halifax, all ministers of health present, with the exception of Alberta's, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 (see Annex C). Her letter provided the federal interpretation of the *Canada Health Act* as it related to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics that also receive funding for these services from provincial/territorial health insurance plans. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995, as set out in Minister Marleau's letter. These penalties are in the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer.

Compliance

Investigations

Compliance with the *Canada Health Act* is monitored through review of provincial and territorial submissions to the Canada Health Act Annual Report, through other provincial and territorial reporting mechanisms, through monitoring media reports of health care issues, and through complaints and enquiries received from the general public or from concerned organizations and medical personnel.

Health Canada's approach to resolving possible compliance issues emphasizes transparency, consultation and dialogue. In most instances, issues are resolved through consultation and discussion with the provinces and territories, based on a thorough examination of the facts. Penalties are only applied when other means of resolving issues have failed.

Of the three compliance issues under investigation in 1999-2000, the issue regarding queue-jumping by an individual in Alberta in relation to eye surgery has been resolved. With respect to the other issues mentioned in the Canada Health Act Annual Report 1999-2000, consultations with the provinces affected are ongoing.

Compliance Issues Raised in 2000-2001

During 2000-2001, Health Canada initiated investigations on three specific issues – the provision of abortion services, user charges, and Magnetic Resonance Imaging (MRI) services at private clinics.

Abortion Services

The federal government continues to work with provincial and territorial governments in an effort to ensure that, in all provinces where abortion clinics exist, this service is provided to residents as a fully insured service on uniform terms and conditions.

Officials from Health Canada and the New Brunswick Ministry of Health and Wellness met in January 2001 to discuss this outstanding federal concern. Additional information-sharing continues between the two levels of government on this issue.

Outstanding abortion issues also exist in Prince Edward Island, Quebec and Manitoba. In each case, Health Canada officials have raised the issue with their provincial counterparts.

User Charges

In June 2000, Health Canada learned that an insured resident of British Columbia had privately purchased insured health services at a surgical centre in the province under the guise of third-party payment. By so doing, the individual in effect jumped the queue for treatment.

Officials from Health Canada and British Columbia conducted an exchange of correspondence on this matter. Work continues on the issue.

Magnetic Resonance Imaging (MRI)

Private MRI clinics exist in British Columbia, Alberta and Quebec. At issue are patient charges at these clinics for medically necessary MRI services. Health Canada is continuing its discussions and information-sharing concerning the provision of MRI and other high-technology diagnostic services in an effort to ensure that patients are not being charged for these services when they are medically necessary.

Deductions

With respect to fiscal year 2000-2001, the Canada Health and Social Transfer for Nova Scotia was reduced by $4,817 per month, or $57,804. This mandatory penalty was applied because Nova Scotia does not pay the facility fees charged for abortions performed at a private clinic. Nova Scotia was the only province in 2000-2001 for which a deduction was made for non-compliance with the *Canada Health Act*.

Please refer to Annex D for a detailed chart of all discretionary and mandatory penalties under the *Canada Health Act*, and Annex E for further information on the Canada Health and Social Transfer.

Chapter 2 - Provincial and Territorial Health Care Insurance Plans in 2000-2001

During 2000-2001, provincial and territorial governments continued to provide access to a comprehensive range of hospital, physician, and extended health care services. The information in this chapter was provided by the provinces and territories, and describes how the health care insurance plans operated within the context of the *Canada Health Act* for the fiscal year ending March 31, 2001.

All provinces and territories provide a range of health services that go beyond the requirements of the *Canada Health Act*. These additional benefits include programs such as pharmacare, home care, ambulance services, and aids to independent living. Such services and benefits are provided at provincial and territorial discretion, on their own terms and conditions.

The purpose of this chapter is to demonstrate the extent to which the provincial and territorial health insurance plans fulfilled the requirements of the *Canada Health Act* during this time. In order to help ensure consistency and thoroughness, provincial/territorial submissions have been prepared according to a template that Health Canada discussed with representatives in each province and territory. Officials were asked to provide narrative descriptions of their health insurance plans according to the program criteria areas of the *Canada Health Act*. In addition, provinces and territories were asked to describe how their governments met the *Canada Health Act* requirement for recognition of federal contributions in support of insured and extended health care services. Finally, provincial and territorial officials were asked to describe the range of extended health care services provided in their jurisdictions; where extended health care includes nursing home intermediate care services, adult residential care services, home care services, and ambulatory health care services.

Following a joint review with the provinces and territories of material submitted for the 1999-2000 Annual Report, further improvements were made to ensure the completeness, consistency and accuracy of the information in the new report. Another change to the reporting process for 2000-2001 has been the submission by provinces and territories of published documents and materials that relate to the five criteria of the *Canada Health Act*, as well as to the recognition condition. These documents were provided by each jurisdiction or were found on provincial or territorial government websites.

Please note that the description of Quebec's health insurance plan was submitted according to the format used in previous editions of the Canada Health Act Annual Report. Quebec chose not to submit its information in the manner and detail requested by Health Canada, as noted in a preface to Quebec's narrative.

Newfoundland and Labrador

Introduction

Fourteen regional boards operate most health services in Newfoundland and Labrador. Of these, eight are institutional health boards, four are community services boards and two are integrated boards, delivering both institutional and community services. Included in the eight institutional boards is a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

The provincial government appoints health boards, whose members serve as volunteers. These boards are responsible for delivering health services to their regions and, in some cases, to the Province as a whole, interacting with the public to determine health needs. They receive their funding from the provincial government, to which they are accountable. The Department of Health and Community Services provides the boards with policy direction and monitors programs and services.

In Newfoundland and Labrador almost 20,000 health care providers and administrators provide health services to the 536,400 residents of the province.

Planning for the future of the Province's health care system requires a clear understanding of the Province's main challenges. These are:

- rapidly rising costs that threaten the affordability of Medicare;
- an aging population that generally requires more services than younger groups;
- the cost of new drugs and advanced technologies;
- rising salaries and fees in other provinces that cause pressure for raises in Newfoundland and Labrador; and
- the need for more investment in early intervention and prevention in order to promote wellness.

Planning will include decision making based on the principles of accessibility, quality, accountability and sustainability. The major planning areas include health services structure, funding, and human resources; a wellness focus; the health services delivery model; and accountability.

Highlights of Initiatives in 2000-2001

The Government of Newfoundland and Labrador made a significant investment in health care in 2000-2001, raising health and community services expenditures to approximately 42 per cent of all government program expenditures. $136 million in new spending was committed for 2000-2001.

The total Health and Community Services budget for 2000-2001 was nearly $1.3 billion, the largest budget of all government departments in the Province.

A special review team was established in 2000-2001 to work with institutional boards to identify core services, priorities, new directions and efficiencies. The work of the review teams and the boards was essential in identifying ways to optimize our health system, and begin to define the system of the future.

In 2000-2001, the Government allocated $23.7 million to modernize diagnostic and therapeutic equipment in health facilities. Of this amount, $8.8 million came from the federal government as part of the First Ministers' Agreement on Health Renewal. Purchases will include new and replacement equipment to improve patient throughput and reduce travel inconveniences in some rural areas.

Hundreds of millions of dollars have been committed over the past five years for new health facilities and renovations of existing health facilities.

A sum of $138 million has been allocated for the redevelopment of major hospital services in St. John's which is scheduled for completion in 2001. St. John's is the major centre for referrals for all areas of Newfoundland and Labrador.

Redevelopment includes the new state-of-the-art Janeway Children's Health and Rehabilitation Centre that will provide in-patient facilities for 103 children; transfer of adult acute services from the Grace General Hospital to St. Clare's Mercy Hospital and the Health Sciences Centre, and closure of the Grace. Upgrades have also taken place at the Miller Centre at an additional cost of $2.6 million.

In addition to redevelopment in St. John's, two new hospitals opened in other areas of the province. In Happy Valley-Goose Bay, a new 24-bed health centre opened in 2000-2001. The total cost of this facility was $30.5 million. A new 21-bed Harbour Breton health centre also opened at a cost of $8.4 million.

Enhanced community based services were achieved through the implementation of the new *Child, Youth and Family Services Act*, and through other initiatives such as the National Child Benefit program. In addition, the Government approved $410,000 in the 2000-2001 fiscal year to support children with autism. This is part of the government's three-year $2.2 million commitment for autistic children in Newfoundland and Labrador.

The Government also allocated another $300,000 in 2000-2001 for implementation of a tobacco reduction strategy, and maintained its commitment to curb smoking among youth. This is part of a $900,000 commitment over three years to reduce smoking in the Province.

One million dollars was committed in 2000-2001 for increases in subsidies and rates for the personal care home industry.

The Government also approved $3.3 million for improved road ambulance services in the Province.

Almost $1 million was approved to continue pilot projects in Happy Valley-Goose Bay, Twillingate and Port aux Basques to seek innovative ways to deliver primary health care through a team approach to health and well-being.

A sum of $6 million was provided for a King Air 350 air ambulance to replace the old King Air 100.

Additional funding of $5.4 million was provided for the coverage of new and proven drugs under the Province's drug program, and for increased utilization.

The Government allocated $600,000 to give incentives to graduating student nurses who commit to work in the province. Government also allocated $75,000 of a three-year $225,000 program to assist nursing students in gaining experience in rural areas of the province. $1.2 million was allocated for the hiring of Nurse Practitioner program graduates.

An amount of $2.1 million was budgeted to hire new salaried physicians. This was in addition to approximately $8.5 million annualized funding provided in 1999-2000 for more than 50 salaried physicians. A further $1.9 million was added to the $32 million Physician Services Memorandum of Understanding (MOU) in 2000-2001 because of increased numbers of fee-for-service physicians in the province.

Additional information on health and health care in Newfoundland and Labrador is available from the website of the Department of Health and Community Services at:

www.gov.nf.ca/health/

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department of Health and Community Services include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and are audited by the Auditor General of the Province.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act provides that the Minister may make regulations for the provision of insured services upon uniform terms and conditions to residents of the Province under the conditions specified in the *Canada Health Act* and Regulations. Governing regulations include the Hospital Insurance Regulations.

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999 and came into force on April 1, 2000. This Act replaced the *Medical Care Insurance Act*, which was previously in effect. Essentially, the new act discontinued the Medical Care Commission previously responsible for the administration of the MCP, with Plan resources being integrated with the Department of Health and Community Services.

The MCP facilitates the delivery of comprehensive medical care to all residents of the Province by implementing policies, procedures, and systems that permit appropriate compensation to providers for the rendering of insured professional services.

The MCP operates in accordance with the provisions of the *Medical Care Insurance Act*, (1999) and Regulations, and in compliance with the criteria of the *Canada Health Act*.

1.2 Reporting Relationship

The Support Services Branch of the Department of Health and Community Services is mandated with the administration of the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes, e.g., Public Accounts.

The Government has created the Strategic Social Plan (SSP) to be able to measure progress towards its goals and objectives and to report publicly on the results. A Social Audit currently under development uses process indicators to measure outputs and impact indicators to measure outcomes. Public accountability for health care is a major part of the Social Audit component of the SSP.

In September 2000 the Government established an Accountability Policy Framework for public bodies, including health boards, which will lead to better planning, performance monitoring and reporting. In the health sector, the Accountability Policy Framework will help ensure that financial and human resources are used efficiently and effectively to address the health needs of the population and improve health system performance.

1.3 Audit of Accounts

Each year the Province's Auditor General performs an independent examination of provincial public accounts. MCP expenditures are now considered a part of the public accounts. The Auditor General has full and unrestricted access to the MCP records.

Hospital boards are subject to Financial Statement Audits, Reviews, and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the boards under the terms of the *Public Tendering Act*. Review engagements and compliance audits are carried out by personnel from the Department of Health and Community Services. Physician audits are performed by personnel from the Department of Health and Community Services under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records are reviewed to ensure that the record supports the service billed and that the service is insured under the Medical Care Plan.

Beneficiary audits are performed by personnel from the Department of Health and Community Services under the *Medical Care Insurance Act* (1999). Individuals are randomly selected on a bi-weekly basis.

The Newfoundland Medical Care Commission Annual Report for the fiscal year 1999-2000, which was released in the fall 2000, provided a status report of the 48 provider audits underway for the Medical Care Plan as of March 31, 2000. As well, 113 beneficiary audits were at various stages of completion at year's end. A report by the provincial Auditor General is included in the *Medical Care Commission Annual Report*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (1990) and the Hospital Insurance Regulations (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are mainly provided in 32 facilities throughout the Province. Insured in-patient services include:

- accommodation and meals at the standard ward level;
- nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations;
- medical and surgical supplies, operating room, case room and anaesthetic facilities; and
- rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology).

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;
- rehabilitative services;
- out-patient and emergency visits;
- day surgery;
- drugs, biologicals and related medically necessary preparations when administered in hospital.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act* (1999).

Other governing legislation under the *Medical Care Insurance Act* include:

- the Medical Care Insurance Insured Services Regulations;
- the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- the Medical Care Insurance Physician and Fees Regulations.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed to practise in the Province by the Newfoundland Medical Board.

In 2000-2001, 755 fee-for-service physicians provided insured services in the province.

Physicians can choose not to participate in the health care insurance plan as outlined in section 12(1) of the *Medical Care Insurance Act* (1999), namely:

"Where a physician providing insured services is not a participating[1] physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

(a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and

(b) provide the beneficiary to whom the physician has provided the insured service with the information required by the Minister to enable payment to be made under this Act to the beneficiary in respect of the insured service."

For purposes of the Act, the following services are covered:

- all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and regulations made under the Act.

[1] The *Medical Care Insurance Act* (1999) defines "participating physician" as a physician who has not made an election, under subsection 7(3), to collect payments in respect of insured services rendered by him or her to residents, otherwise than from the Minister.

There are no limitations on the services covered, provided they qualify under one or more of the conditions listed above.

No services were added in 2000-2001 to the list of insured physician services covered by the health care insurance plan in Newfoundland and Labrador.

Ministerial direction is required to add a physician service to the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial Medical Association. Public consultation is involved.

2.3 Insured Surgical-Dental Services

Surgical-dental treatments properly and adequately provided to a beneficiary and carried out in a hospital by a dentist are covered by the MCP if the treatment is of a type specified in the surgical-dental services Schedule.

All dentists licensed to practise in Newfoundland and Labrador and who have hospital privileges, are allowed to provide surgical-dental services. The dentist's licence is issued by the Newfoundland Dental Licensing Board.

Dentists may opt out of the Plan. The dentists must advise the patient of their opted-out status, stating the fees expected, and providing the patient with a written record of services and fees charged. One dentist is currently in an opted-out category.

Addition of a surgical-dental service to the list of insured services must be approved by the Department of Health and Community Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

- preferred accommodation at the patient's request;
- cosmetic surgery and other services deemed to be medically unnecessary;
- ambulance or other patient transportation prior to admission or upon discharge;
- private duty nursing arranged by the patient;
- non-medically required x-rays or other services for employment or insurance purposes;
- drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital;
- bedside telephones, radios or television sets for personal, non-teaching use;
- fibreglass splints;
- services covered by Workers' Compensation legislation or by other federal or provincial legislation; and
- services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board.

The use of the hospital setting for any services deemed not insured by the Medicare Plan would also be uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care Insurance Act* (1999), the following is a list of non-insured physician services:

- any advice given by a physician to a beneficiary by telephone;
- the dispensation by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for or on behalf of, or any communication to or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an

initial assessment specifically related to diagnosis of the illness proposed to be treated by acupuncture;

- examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;
- plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for the purpose of determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma;
- circumcision of newborns;
- hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside of Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the Province at a facility not approved by the Newfoundland Medical Board;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- *in-vitro* fertilization and OSST (ovarian stimulation and sperm transfer);
- reversal of previous sterilization procedure;
- surgical diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
- other services not within the ambit of section 3 of the Act.

All diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the Province. Hospital policy on access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practise. Patients retain the right to financially upgrade the standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with providers of the service.

Surgical-dental and other services not covered by the Dental Health Plan are the dentists', oral surgeons' or general practitioners' fees for routine dental extractions in hospital, and fluoride dental treatment for children under six years of age.

3.0 Universality

3.1 Eligibility

Newfoundland and Labrador residents are eligible for coverage under the provincial health care program.

The *Medical Care Insurance Act* (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Province, but does not include tourists, transients or visitors to the Province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations identify those residents eligible to receive coverage under the plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the plans include:

- students and their dependants already covered by another province or territory;
- dependants of residents if covered by another province or territory;
- certified refugees and refugee claimants and their dependants;

- foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
- foreign students and their dependants;
- tourists, transients, visitors and their dependants;
- Canadian Armed Forces and Royal Canadian Mounted Police personnel;
- inmates of federal prisons; and
- armed forces personnel of other countries who are stationed in the Province.

3.2 Registration Requirements

Registration under the Medical Care Plan and possession of a valid Medical Care Plan card are required in order to access insured services. New residents are advised to apply for coverage as soon as possible upon arrival in Newfoundland and Labrador.

It is the parent's responsibility to register a newborn or adopted child. The parents of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from the parent's.

Applications for coverage for an adopted child will require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the Department of Health and Community Services. Applications for coverage for a child adopted outside Canada will require Permanent Resident documents for the child.

As of April 11, 2001 there were a total of 616,944 active beneficiaries registered with the Medical Care Plan.

3.3 Other Categories of Individual

Foreign workers and clergy, and dependants of North Atlantic Treaty Organization personnel are eligible for benefits. Holders of Minister's Permits are also eligible, subject to Plan approval.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage as of the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage as of the day of arrival. The same applies to discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the Medical Care Plan. Immediate coverage is provided to persons from outside Canada who are authorized to work in the Province for one year or more.

4.2 Coverage During Temporary Absences In Canada

Coverage is provided to residents during temporary absences within Canada. The Province has entered into formal agreements with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing arrangement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the Province at least four consecutive months in each 12-month period to qualify as a beneficiary. Generally, the rules regarding

medical and hospital care coverage during absences include:

- prior to leaving the Province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate;
- beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate for up to 12 months' duration. Upon return, beneficiaries are required to reside in the Province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months' coverage;
- students leaving the Province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located outside the Province;
- persons leaving the Province for employment purposes may receive a certificate for up to 12 months' coverage. Verification of employment may be required;
- persons must not establish residency in another province, territory, or country while maintaining coverage under the Newfoundland Medical Care Plan;
- for out-of-province trips lasting 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request;
- for out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside province; and
- failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the Province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. The maximum amount payable by the Government's hospitalization plan for out-of-country in-patient hospital care is $350 per day if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness, and are also insured for elective services, when they are not available in the Province or within Canada. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province in which they are available.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories.

If a resident of the Province has to seek specialized hospital care outside the country because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department of Health and Community Services. The referring physicians must contact the Department or the Medical Care Plan for prior approval.

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the Plan so that patients may be made aware of any financial implications. General practitioners and

specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the Province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for hospital services and no extra-billing by physicians in the Province.

5.2 Access to Insured Hospital Services

As of March 31, 2000 Newfoundland and Labrador had 1,643 staffed hospital beds in 14 hospitals and 18 community health centres, including 1,417 acute care beds, 22 rehabilitation beds, and 204 psychiatric beds.

Information on acute care beds used for day-care services is not available.

The total number of practising registered nurses in the Province in 2000-2001 was 5,592. Approximately 85 percent of the 2000 graduates chose to remain in the Provinces with the availability of a signing bonus of $3,000. This is available to 2001 graduates for a second year with similar uptake.

There were 12 new nurse practitioner positions created in rural areas, thereby improving public access to primary health care. Nurse practitioner positions have now increased to over 30, with a small number of specialist positions in tertiary care. Licensed practical nurse enrolment has increased steadily since 1999. Other initiatives include nurse practitioner student bursaries; a six to nine percent remuneration increase for Registered Nurses and approximately three percent for licensed practical nurses following occupational reviews of each occupational group; a Northern Incentive package for nurses in remote and northern locations; and a three-year pilot to assist with rural and remote clinical placements of nursing students.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2000, the ratio of Registered Nurses to population in Newfoundland and Labrador (100/10,000) was higher than in other provinces and higher than the rate for Canada as a whole (75.4/10,000). Despite the high Registered Nurse per 10,000 population ratio, some hospitals have experienced shortages of nursing staff, particularly shortages of nurses with specialized training in critical and cardiac care.

There are shortages in other professional groups, such as physiotherapy, speech language pathology, audiology and occupational therapy, as well as psychology. Focused recruitment and incentive programs such as bursaries and seat purchases are in place, and new approaches continue to be developed. The supply of psychologists was enhanced with an amendment to the *Psychologists Act*, which established a Master's degree as the entry level to practise.

With regard to the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- Magnetic Resonance Imaging (MRI) is located in St. John's only;
- Computed Tomography (CT) scanners are available in St. John's (three machines), Clarenville, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- renal dialysis is provided in St. John's, Grand Falls/Windsor and Corner Brook;
- cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and satellite clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- approximately 82 percent of surgery services are provided in St. John's, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony. A full range of basic and some

sub-specialty surgical services is available in all locations. Tertiary surgery, e.g., trauma, cardiac, and neuro is available in St. John's only; and

- an additional 18 percent of surgery services are provided in six mid-sized hospitals at Carbonear, Clarenville, Burin, Stephenville, Happy Valley/Goose Bay and Labrador City. These facilities offer basic surgical services.

A number of significant measures were taken in 2000-2001 to improve access to insured hospital services.

- Access to CT scanning services was improved with the provision of services in Clarenville and Gander. Additional CT units are planned for Carbonear and Happy Valley/Goose Bay in 2001-2002.
- Bone density testing services became available in Gander, Grand Falls/Windsor and Corner Brook.
- The Government approved an annualized investment of $2.7 million in operating funds for the cardiac program to meet current and future demands. In addition, $1.2 million was allocated to renovate and purchase new equipment to enhance the provincial cardiac program. The program in St. John's was expanded by approximately 150 surgeries annually to reduce patient wait times.
- Planning and related activities occurred for a new community based renal dialysis service in Clarenville, scheduled to open in July 2001.
- New hospitals became operational in Harbour Breton and Happy Valley/Goose Bay. Capital redevelopment and related planning and design activities continued in Gander, Fogo, Stephenville, and Bonne Bay.
- the Cervical Cancer Screening Program in Western Newfoundland was allocated $130,000 for 2000-2001.

5.3 Access to Insured Physician and Dental-Surgical Services

The number of physicians practising in the Province is relatively stable. The Department of Health and Community Services is working with regional health boards to develop a human resource plan for physicians based on the principle of access to services.

Improvement in salary scales and retention bonuses for salaried physicians reflective of geography have been implemented to improve rural recruitment. Premiums on hospital-based services provided by general practitioners in rural hospitals have also been applied.

Service levels and accessibility (wait time) issues are monitored by regional health boards with adjustments made as required, such as increasing the number of cardiac surgeries performed weekly.

During 2000-2001, 12 new physicians who entered practice had at some point received financial assistance from the Department of Health and Community Services through the Travelling Fellowship Program, the Medical Specialist Resident Bursary Program, the Medical Student and Resident Practice Incentive Program or the Psychiatry Resident Bursary Program.

With regard to surgical-dental services, four certified dental surgeons and one non-certified oral surgeon practised in the Province. A total of 21 general-practice dentists have hospital privileges.

5.4 Physician Compensation

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association, with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. The dispute resolution mechanism agreed to as a result of the current negotiations is mediation. The term of the current agreement is from April 1, 1999 to September 30, 2002.

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract, and sessional block funding.

5.5 Payments to Hospitals

The Department of Health and Community Services is responsible for funding the Regional Health Care Boards and Health and Community Services Boards for ongoing operations and capital equipment purchases. Funding for insured services is provided to the Boards as an annual global budget and these annual funds are distributed in 12 monthly advance payments. As part of their accountability to the Government, Boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. This process is consistent for all Regional Health Care Boards, Health and Community Services Boards and other grant-funded organizations within the Province.

Payments are made to Regional Health Care Boards and Community Health Services Boards in accordance with the *Department of Health and Community Services Act* and the *Hospitals Act*.

All Regional Health Care Boards and Health and Community Services Boards operate on a global budget basis, whereby funding provided by the Province for approved programs is allocated by the Boards. The global budgeting process devolves the budget allocation authority, responsibility, and accountability to all appointed Boards in the discharge of their mandates.

Throughout the fiscal year, the Health Boards may forward additional funding requests to the Department of Health and Community Services for changes in program areas or increased workload volume. These requests will be reviewed, and if approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for negotiated salary increases, additional approved positions or program changes are funded based on the implementation date of such increases and the cash flow requirement in a given fiscal year.

Boards are continually facing challenges in providing the required health care services and increased demands of the health system when costs are rising, staff workloads are increasing, patient expectations are higher, and new technology introduces new demands for time, resources, and funding. Boards are continuing to work with the Department of Health and Community Services to address these issues and provide effective, efficient and quality health care.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador through press releases, government websites, and various other documents. For fiscal 2000-2001 these documents included the following:

- the 1999-2000 Public Accounts Volume I,
- the Estimates 2001-2002, and
- the Budget Speech 2001

These reports were tabled by the Government to the House of Assembly and are publicly available to Newfoundland and Labrador residents.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community based programs as an alternative to hospital services. These programs are provided by seven regional Boards. Services include the following.

Nursing Home Services

Long-term residential accommodations are provided for clients requiring high levels of nursing care in 18 community health centres and 19 nursing homes. There are approximately 2,800 beds located in these 37 facilities. Residents pay a maximum of $2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department of Health and Community Services.

Personal Care Homes

Persons requiring protective oversight or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,400 beds located in 103 homes across the Province. These homes are operated by the private for-profit sector. Residents pay a maximum of $968 per month, based on an individual client assessment using standardized financial criteria. In 2000-2001, an additional 136 subsidies were provided under a five-year plan to enable more elderly persons to access this type of residential service.

Home Care Services

Home care services include professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed with six regional Boards.

Non-professional services include personal care, household management, respite and behaviourial management. These services are delivered by home support workers through agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial criteria. The 2000 ceiling for home support services was $2,268 for seniors and $3,240 for the physically and developmentally delayed population.

Special Assistance Program

The Special Assistance Program is a provincial program that provides basic supportive services to assist financially eligible clients in the community with activities of daily living. The benefits include access to health supplies, oxygen, orthotics and other equipment.

Drug Programs

The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who are in receipt of the Guaranteed Income Supplement and who are registered for Old Age Security benefits. Eligible individuals are provided coverage for the ingredient portion of the prescription. Any additional cost, such as dispensing fees, are the client's responsibility. Income support recipients are eligible for the income support drug program, which covers the full cost of benefit prescription items, including markup amount and dispensing fee.

Other Programs

The Department of Health and Community Services administers the Emergency Air and Road Ambulance programs through the Emergency Health Services Division. The Air Ambulance Program provides transportation and medical care to patients within the Province of Newfoundland and Labrador, and to hospitals outside the Province where warranted. Air Ambulance will also transport patients, medical staff and equipment to and from isolated communities when required. The Road Ambulance Program provides medical care and transportation to residents accessible by road at a reasonable cost to the user. User fees are charged for both Road and Air Ambulance Program use.

Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance Plan and the Medical Care Plan. Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the Province, may qualify for financial assistance under the Medical Transportation Program.

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at 6-month intervals; cleanings at 12-month intervals; fluoride applications for children ages 6 to 12 at 12-month intervals; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. These basic services are also available under the income support component to recipients aged 13 to 17 years. Adults

receiving social assistance are eligible for emergency care and extractions. Beneficiaries covered under the dental plan must pay an amount directly to the dentist for each service provided. In circumstances where the beneficiary is receiving income support, a co-payment is paid by the Dental Health Plan.

Prince Edward Island

Introduction

The Ministry of Health and Social Services is a very large and complex system of integrated services that protect, maintain and improve the health and well-being of Islanders.

The continued sustainability of the system is a primary concern. Spending on health and social services has grown rapidly in recent years to 42 percent of total provincial government program expenditures. At this rate of growth, spending could reach 50 percent of overall spending within the next five years. The availability of health professionals is also affecting our ability to sustain services.

We are concerned about the high rate of chronic conditions in our province; conditions such as cardiovascular disease, cancer, diabetes, and mental illness. Wellness initiatives will assist Islanders to increase acceptance of responsibility for their health and reach their full health potential. This will be achieved through community partnerships to promote healthy lifestyles and reduce risk factors for chronic disease, and through increased access to primary health services that support disease prevention and management.

Recruitment, retention and human resource planning will remain a priority to ensure an adequate supply and appropriate mix of health and social service professionals to meet changing needs. Retention initiatives will be supported by comprehensive workplace wellness programs to promote organizational excellence, positive personal health practices, and safe, positive workplaces.

Overview of the Health and Social Services System

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*. Many other health and social services are funded in whole, or in part, by the provincial government.

The system includes a wide range of integrated health and social services such as acute care, addictions, mental health, social assistance and housing services. Some specialty services such as cardiac surgery and neurotrauma services are within the purview of the regional health care system.

Facilities

PEI has two referral hospitals and five community hospitals, with a combined total of 474 beds. Along with seven government manors that house 546 long-term care nursing beds, Islanders have access to an additional 407 beds in private nursing homes. The system also operates several addictions and mental health facilities, 1,178 seniors' housing units, and 460 family housing units.

A new 40-bed provincial addictions facility and a new provincial Cancer Treatment Centre were opened in 2000. Construction of a new $50 million health facility will be completed in Summerside in 2003. CT scanning and a wide range of diagnostic imaging services are available at the referral hospitals, and new linear accelerator and MRI services are now being established.

Human Resources

The public sector health and social services workforce has approximately 4,000 employees. Prince Edward Island has 200 health care professionals per 10,000 residents, compared with the national average of 182 per 10,000.[1]

Structure

The system includes the Department of Health and Social Services and five Regional Health Authorities, which are governed by the Regional Health Boards. The Department works with the

[1] Canadian Institute for Health Information, 1997.

Regional Health Authorities to establish system goals and objectives, develop policy and outcome standards, and allocate resources. The Regional Health Authorities plan and deliver core programs and services to meet system standards.

Financial Resources

During the past 10 years, provincial spending on health and social services increased from $250 million to more than $353 million, an average increase of about three percent per year. Increased costs are due to inflation, population growth, new technologies, and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 33%; Social Services, 24%; Long Term Care, 11%; Physician Services, 12%; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 20%.

Combined public and private sector spending per capita is $2,516 per year, compared with a Canadian average of $2,700. Spending as a percentage of provincial Gross Domestic Product is the second highest in the country at 11.7 percent.[2]

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruitment and retention of skilled employees is expected to be a challenge throughout the labour market in coming years as we experience a major demographic shift. The effect of this trend is being felt first in the health sector, which is labour-intensive and dependent on a specialized workforce, and particularly in less-populated areas like Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases, and the supply of available graduates declines. For example, it is expected that in the next 10 years in PEI, 40 percent of the physician workforce and more than 200 nurses will retire from the public sector. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

The demand for services is increasing in almost every area for a variety of reasons, including population growth, the availability of new drugs and technology, and increasing public expectations. People are asking for more doctors, nurses, drugs, technology and family services. They want access to care in their own communities, and they are concerned about wait-lists for services. While rising expectations are creating pressure to increase spending on acute care, they are severely limiting the ability of the system to innovate and shift resources to other areas of need.

Increasing public expectation is a very critical issue. Demand alone cannot drive the system. The public must become more informed of reasonable access and the need for real changes in the way services are delivered, particularly in primary health services.

Appropriate access to primary health services

There is growing evidence that investments in primary health services have a great impact on health and sustainability. Primary health services are those that people access first and most often, such as family physician services, public health nursing, screening programs, addiction services and community mental health services.

Personal health practices

Individuals who understand and accept responsibility for health are more able to take control over and improve their health.

[2] Canadian Institute for Health Information, 1997.

People's capacity to accept responsibility for health is influenced by social and economic conditions, and comprehensive strategies are needed to address these conditions. It is critical that the health system increase its capacity to work with others to assist individuals, families and communities to accept responsibility for, and achieve good health.

Aging population

During the next three decades as baby boomers age, we will experience the biggest demographic shift in history. It is expected that the proportion of the population aged 65 and over in Prince Edward Island will increase from 13 percent today to 15 percent in 2011, and to 27 percent in 2036. This will affect the health system in several ways. The incidence of diseases like cancer, heart disease, diabetes and dementia is expected to increase. Demand is expected to rise for acute care, long term care, home care, mental health and other services. This issue becomes more critical when we consider that the health workforce will be aging at the same time, there will be fewer family members to support their aging parents, and the amount of resources required to sustain services for seniors could negatively affect other government services that support health. It is critical that the health system be prepared to meet these changing needs.

Disease prevention and management

Many diseases are preventable. For example, meningitis can be prevented through vaccines, and the spread of sexually transmitted diseases can be prevented through responsible sexual behaviour. Many chronic conditions are also preventable. Risk factors for cardiovascular disease and cancer can be reduced or eliminated through education and supports that result in a change in lifestyle.

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid 1970s, compared with 45 cases per month in the mid 1990s. It is projected that this number will grow to 65 cases per month in 2006. There is clear and undisputable evidence that good blood sugar control can prevent or delay the onset of serious complications from diabetes, such as heart disease, blindness and kidney disease, which have enormous human and financial costs. The prevalence of cancer and diabetes in this province is expected to increase significantly as the population ages. It is imperative that our system step up its efforts to assist Islanders to prevent, delay and manage these conditions.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan, under the authority of the Minister of Health and Social Services, is the vehicle for the delivery of hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988), which insures services as defined under section 2 of the *Canada Health Act*.

Under Part I of the Act, it is the function of the Minister, and the Minister has the power to:

- ensure the development and maintenance throughout the Province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;
- approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;
- approve or disapprove all grants to hospitals for construction and maintenance;
- establish and operate, alone or in cooperation with one or more organizations, institutes for training of hospital and related personnel;
- conduct surveys and research programs and to obtain statistics for its purposes;
- approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations;
- subject to the approval of the Lieutenant Governor in Council, to do all other acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

In addition to the duties and powers enumerated in Part I of the Act, it is the function of the Minister, and the Minister has power to:

- administer the plan of hospital care insurance established by this Act and the Regulations;
- determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance, and to make retroactive adjustments with hospitals for under-payment or over-payment for insured services according to the cost as determined in accordance with the Act and the Regulations;
- receive and disburse all monies pertaining to the plan of hospital care insurance;
- approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance;
- enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons;
- to prescribe forms necessary or desirable to carry out the intent and purposes of the Act;
- appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon;
- appoint medical practitioners with the duty and power to examine and obtain information from the medical and other hospital records, including patients' charts with medical records and nurses' notes, reports, and accounts of patients who are receiving or have received insured services;
- appoint inspectors with the duty and power to inspect and examine books, accounts, and records of employers and collectors to obtain information related to the hospital and insurance plan;
- withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;
- act as a central purchasing agent for the purchase of drugs, biologicals, or related preparations for all hospitals in the Province, to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the Province and to withhold or reduce payments under this Act to a hospital that does not comply with regulations respecting the purchasing of drugs, biologicals or related preparations; and
- supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under this Act to a hospital that does not comply with the regulations respecting the use of such aids and procedures.

The Health Ministry, through the Department of Health and Social Services, has the responsibility for the overall efficiency and effectiveness of the provincial health system. Specifically, the Department is responsible for:

- setting overall directions and priorities;
- developing policies and strategies, legislation, provincial standards and measures;
- monitoring provincial health status;
- monitoring and ensuring that the five regional health authorities comply with regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the five regional health authorities;
- improving the quality and management of a comprehensive province-wide health information system;
- ensuring access to high-quality health services;
- addressing emerging health issues and examining new technology before implementation; and
- directly administering certain services and programs.

The five regional health authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and

hire physicians, nurses and other health-related workers. Their responsibilities include:

- assessing the health needs of residents in their regions;
- providing for the input and advice of their residents;
- allocating and managing resources, setting priorities, hiring staff and making the best use of available resources;
- consulting with other organizations involved in the health field;
- developing policies, standards and measures;
- planning and coordinating with the Department and other authorities the delivery of the full range of health services;
- promoting health and wellness in their communities;
- making information available to residents on choices about health and health services;
- ensuring reasonable access to health services; and
- monitoring, evaluating and reporting on performance to residents and to the Ministry.

1.2 Reporting Relationship

An annual report is submitted by the Department of Health and Social Services to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions, and statistical highlights for the year.

Each of the five regional health authorities are required by statute to submit an annual report to the Minister of Health and Social Services. The Minister has the authority to request other information as deemed necessary on the operations of the Authorities and their delivery of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The provincial auditor general conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department of Health and Social Services.

Each Regional Health Authority has the responsibility to engage its own public accounting firm to conduct annual financial statement audits. The audited financial statements are provided to the Ministry and the Department of the Provincial Treasury. The reports are presented at public meetings held annually within each region. Audited statements are also presented to the Legislative Assembly and included within the published Public Accounts of the Province of Prince Edward Island.

The provincial auditor general, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program-specific basis with respect to the operations of the Department of Health and Social Services, as well as each of the five Regional Health Authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in-patient and out-patient hospital services which are available at no charge to a person who is eligible. Insured hospital services include:

- necessary nursing services;
- laboratory;
- radiological and other diagnostic procedures;
- accommodations and meals at a standard ward rate;

- formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital;
- operating room, case room and anaesthetic facilities;
- routine surgical supplies; and
- radiotherapy and physiotherapy services performed in hospital.

As of March 2001, there were seven acute care facilities participating in the Province's insurance plan. In addition to 454 acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, as defined under the *Hospitals Act* (1988) and seven insured chronic care beds. An additional facility, Prince Edward Home, has 50 insured chronic care beds. In addition, Prince Edward Island utilizes the equivalent of 60 acute care beds outside the Province.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988). Amendments were passed in 1996. Changes were made to include the physician resource planning process.

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The number of practitioners who billed the insurance plan as of March 31, 2001 was 215.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Insurance Plan is not eligible to bill the plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that the physician advise the patient that he or she is not a participating physician or practitioner and provide the patient with sufficient information to enable them to recover the cost of services from the Minister of Health.

Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside of the Plan, or selectively opt out of the plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2001 no physicians had opted out of the health care insurance plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include:

- most physicians' services in the office, at the hospital or in the patient's home;
- medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary;
- obstetrical services, including pre- and post-natal care, newborn care or any complications of pregnancy such as miscarriage or Caesarean section;
- certain oral surgery procedures performed by an oral surgeon when it is medically required that they be performed in a hospital;
- sterilization procedures, both female and male;
- treatment of fractures and dislocations; and
- certain insured specialist services, when properly referred by an attending physician.

No services were added to the list of insured physician services in 2000-2001.

The process to add a physician service to the list of insured services is negotiated between the Department of Health and Social Services and the medical society of the Province.

2.3 Insured Surgical-Dental Services

Dental services are not an insured service in the Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in

the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital as confirmed by the attending physician.

The addition of a surgical-dental service is conducted through negotiations with the Dental Association and the Department of Health and Social Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include:

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by the Department;
- advice or prescriptions by telephone, except anticoagulant therapy supervision;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from the Department;
- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- testimony in court;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
- reversal of sterilization procedures;
- *in vitro* fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and
- any other services that the Department may, upon the recommendation of the Medical Advisory Committee, declare to be non-insured.

Provincial hospital services not covered by the Hospital Services Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals, and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of the Department of Health and Social Services.

The process to de-insure services by the Health Care Insurance Plan is done in collaboration with the Medical Society and Department of Health and Social Services.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations; section 3 defines eligibility to the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital

and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Armed Forces (CAF), Royal Canadian Mounted Police (RCMP), inmates of a federal penitentiary, and those who are eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in the following cases: members of the CAF, RCMP, and penitentiary prisoners on discharge, release, or release following the termination of rehabilitation leave where such is granted by the CAF, the province where incarcerated or stationed at time of release of discharge, or the province where resident on the completion of rehabilitation leave as may be appropriate will provide initial coverage for the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

Foreign students, tourists, transients, or visitors to Prince Edward Island do not qualify as residents of the Province and are therefore not eligible for hospital and medical insurance benefits.

3.2 Registration Requirements

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks prior to renewal.

The number of residents registered for the health care Insurance plan in Prince Edward Island as of March 31, 2001 was 138,205.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward !sland. There were 58 Kosovar Refugees registered for Medicare as of March 31, 2001.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the Province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences, must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the Province, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the Province for up to 182 days in a 12-month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the Province under the above circumstances must notify the Registration Department prior to leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

The payment rates are $576 per day for hospital stays. The standard inter-provincial out-patient rate is $110. The methodology used to derive these rates are as if the patient had the services provided on Prince Edward Island.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

Insured residents may be temporarily out of the country for a 12-month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For Island residents travelling outside of Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department.

The amount paid for insured emergency services outside of Canada for 2000-2001 was $75,500.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency out-of-province medical or hospital services. Prince Edward Island residents seeking such required services may apply for prior approval through a PEI physician. Full coverage may be provided for (Prince Edward Island-insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department of Health and Social Services to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The seven acute care facilities in Prince Edward Island have a total of 474 (454 acute care + 20 rehabilitative) approved beds. There are also 16 acute care beds providing insured hospital services in a psychiatric facility. There are no admission data for these 16 beds. During the 2000-2001 fiscal year, the total number of in-patient admissions was 18,340. The number of in-patient days in Prince Edward Island hospital acute care beds totalled 142,302 (excluding newborns), with an average stay of 7.8 days. Due to system changes, out-of-province hospital data for 2000-2001 are not available at this time. There are no data available on admissions, length of stay, and in-patient days for chronic care beds.

Linear Accelerator

In April 2000, the Government announced plans to expand the range of services that can be provided at the PEI Cancer Treatment Centre, through the addition of linear accelerator services. An impact analysis and functional plan for expanded cancer treatment services is now in the process of being completed. Expanded cancer treatment services are expected to be operational in late 2002.

Magnetic Resonance Imaging (MRI)

In April, 2000, the Government announced that diagnostic imaging services for Islanders will be expanded through the purchase of a Magnetic Resonance Imaging (MRI) unit for the Queen Elizabeth Hospital. A committee has been established to oversee the planning phase for the establishment of the MRI service, which is

expected to be operational in late 2002. An impact analysis has been completed and the functional plan is in the process of being finalized.

Ambulance Services

Amendments to the *Public Health Act* related to Emergency Medical Services and accompanying Regulations were approved for proclamation January 1, 2001. This act provides for enhancements in administration and delivery of emergency medical services.

In April 2000, the Government announced the Out of Province Medical Transport Support Program to cover a portion of the cost of out-of-province ground ambulance transportation. This program reduces the user fee for eligible Island residents who need specialized medical care outside the province.

Accessibility – New Initiatives

The Nurse Recruitment Strategy, announced in the 2000 PEI Budget, is in its second year of operation. All strategies have been implemented in PEI. While the Nurse Recruitment Strategy addresses all sectors of health care, priority is given to the institutional sector, which is acute and long term care services. The Department is currently developing an evaluation framework for the formal evaluation of the strategies.

5.3 Access to Insured Physician and Dental-Surgical Services

Physician services are accessible throughout the Province except for specialties where there are vacancies. Recruitment processes were undertaken for family physicians, one ear, nose and throat specialist, psychiatrists, a radiologist and one obstetrician. A recruitment strategy was announced that included incentives for recent graduates and new recruits, and an increase in medical seat resources for Prince Edward Island residents at medical schools outside the Province.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and government to represent their interest in the process. A new three-year agreement was negotiated and is in effect until March 31, 2004.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments.

5.5 Payments to Hospitals

Regional Health Authorities are responsible for the delivery of hospital services in the Province under the *Health and Community Services Act*. The financial (budgetary) requirements are established annually through consultation with the Department of Health and Social Services and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to the Regional Health Authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The normal funding method includes the use of a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 2000-2001 Annual Budget and related budget documents, and its 2000-2001 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not an insured service, with the exception of the insured chronic care beds noted in section 2.1. Extended care services are provided through the five Regional Health Authorities of the Health and Social Services system. Nursing home services are available upon approval from regional admission and placement committees for placement into government manors and licensed private nursing homes. The standardized Services Assessment Screening Tool is used for determining service needs of residents for all admissions to nursing homes. There are 18 government and private nursing home facilities in the Province, with a total of 953 beds, including respite beds. The Province subsidizes 71 percent of residents in nursing homes as per the Welfare Assistance Act Regulations, Part 2. The federal government subsidizes approximately eight percent of residents. The remaining 21 percent of residents pay their own way. Nursing homes in Prince Edward Island provide Levels 4 and 5 care.

In addition to nursing home facilities, there are 31 licensed community care facilities in Prince Edward Island. As of March 31, 2001, the total number of licensed community care facility beds was 871. The 31 percent of residents who are subsidized require a financial assessment as per the *Welfare Assistance Act*, Part 1. The remaining 69 percent pay their own way. Community Care facilities provide Levels 1 to 3 care.

Home Care and Support services, also uninsured, are another component of extended care. Support services include home care nursing, visiting homemakers, community support, adult protection, and occupational and physiotherapy supports. The Senior's Assessment Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client but are subject to a budget cap. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment. The demand for home care continues to increase in PEI.

Nova Scotia

Introduction

The year 2000-2001 took Nova Scotia further toward its goal of developing an affordable, high quality, sustainable health care system. The main thrust of this change involved the passage of the *Health Authorities Act*, which came into effect on January 1, 2001, to establish nine District Health Authorities (DHAs) that will be charged with the management of day-to-day health services delivery.

This new legislation ensures greater financial accountability. The DHAs will be required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. Required annual reports will provide updates on the implementation of DHA business plans. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

In addition, a clinical services planning process was initiated to anticipate required changes in the system to ensure that Nova Scotians, no matter where they live, receive reliable high quality and sustainable health services. The results of that planning process were released and shared with the nine DHAs in February 2001 in a document entitled *Making Better Health Care Decisions for Nova Scotia*.

During this ongoing period of change, Nova Scotia has remained committed to the delivery of medically necessary services that are consistent with the principles of the *Canada Health Act*.

Additional information related to health care in Nova Scotia may be obtained from the Department of Health website at:

www.gov.ns.ca/health

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Insurance Plan (HSI) and the Medical Services Insurance Plan (MSI). The Department of Health administers the HSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, 35, passed by the Legislature in 1958.

The MSI is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Maritime Medical Care Incorporated, under the legislation previously mentioned (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32, 35).

Section 3 of the *Health Services and Insurance Act* states that subject to this act and the Regulations, all residents of the Province are entitled to receive insured hospital services from hospitals on uniform terms and conditions, and that all residents of the Province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend, or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Maritime Medical Care Incorporated (MMC), by virtue of the 1992 Memorandum of Agreement, is mandated to:

- determine the eligibility of providers participating in the Plan;
- plan and conduct information and education programs necessary to ensure that all persons and providers are informed of

their entitlements and responsibilities under the Plan;

- make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable; and
- develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfil its mandate.

1.2 Reporting Relationship

Maritime Medical Care is required to submit to the Province, no later than the twentieth day of each month, monthly expenditure reports, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, MMC is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. MMC is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc., that are charged to the MSI Plan. Reports prepared by Maritime Medical Care are forwarded directly to the Insured Programs Branch of the Department of Health for review and follow-up.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the Hospital Insurance Regulations, which relate to this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health, their annual budget estimates and their monthly reports of actual revenues and expenditures.

1.3 Audit of Accounts

The Auditor General's office audits Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Maritime Medical Care. MMC also has an external audit conducted, which includes the administrative contract. No official audit is performed on Medicare payments, however, this is being recommended by the Auditor General's office.

Under Section 12(2) of the Hospital Insurance Regulations, every hospital board is required to submit to the Minister of Health by May 31 each year, an audited financial statement for the preceding fiscal year.

The Report of the Auditor General of Nova Scotia, tabled on January 19, 2001, contained three audits that are relevant to the *Canada Health Act*:

- a broad scope audit of government user fees in the Department of Health;
- an audit of the Cape Breton Healthcare Complex; and
- an assessment of the Alternative Funding Initiatives for the remuneration of Nova Scotia physicians.

1.4 Designated Agency

Maritime Medical Care Incorporated administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement between the Department of Health and MMC. MMC receives written authorization from the Department on the payees to which it may make payments. The rates of pay and specific amounts are dependent on the physician contract negotiated between the Medical Society of Nova Scotia and the Department of Health. MMC abides by the terms and conditions of the contract and its payment mechanism.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Thirty-six facilities deliver insured hospital services to in-patients and out-patients in Nova Scotia. Accreditation is not mandatory but most facilities are accredited at a facility or regional level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made

pursuant to the *Health Services and Insurance Act*.

In-patient services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations, when administered in a hospital;
- routine surgical supplies;
- use of operating room, case room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available; and
- blood or therapeutic blood fractions.

Out-patient services include:

- laboratory and radiological examinations;
- diagnostic procedures involving the use of radio-pharmaceuticals;
- electroencephalographic examinations;
- use of occupational and physiotherapy facilities, where available;
- necessary nursing services;
- drugs, biologicals and related preparations;
- blood or therapeutic blood fractions;
- hospital services in connection with most minor medical and surgical procedures;
- day-patient diabetic care;
- services other than medical services provided by and within the Nova Scotia Hearing and Speech Clinic;
- ultrasonic diagnostic procedures;
- home parental nutrition; and
- haemodialysis and peritoneal dialysis.

2.2 Insured Physician Services

The Legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35, and the Medical Services Insurance Regulations.

Under the *Health Services and Insurance Act* a general practitioner means a person who engages in the general practice of medicine or a physician who is not a specialist within the meaning of the clause, and a specialist who is a physician and is recognized as a specialist by the appropriate licensing body of the jurisdiction in which he or she practises. Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2000-2001, 1,946 physicians and 39 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing their billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2001, no physicians had opted out.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

No new large-scale services were added to the list of insured physician services in 2000-2001. On a quarterly ongoing basis, new specific fee codes are approved that represent either enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established must first present their cases to the Medical Society of Nova Scotia, which puts a suggested value on the proposed new fee.

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from the Medical Society and Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Maritime Medical Care is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the *Health Services and Insurance Act* a dentist is defined as a person lawfully entitled to practise dentistry in a place in which such practice is carried on by that person.

To be permitted to provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Association of Dentists and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2001, there were no dentists who had opted out. In 2000-2001, 39 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the Dental Surgical Program Fee Schedule. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Additions to the list of surgical-dental services that are insured are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- preferred accommodation at the patient's request;
- telephones;
- televisions;
- drugs and biologicals ordered after discharge from hospital;
- cosmetic surgery;
- reversal of sterilization procedures;
- surgery for sex reassignment;
- *in-vitro* fertilization;
- procedures performed as part of clinical research trials;
- services such as gastric bypass for morbid obesity, breast reduction/augmentation, and newborn circumcision, except because of medical necessity; and
- services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:

- those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;
- mileage, travelling or detention time;
- telephone advice or telephone renewal of prescriptions;
- examinations required by third parties;
- group immunizations or inoculations unless approved by the Department;
- preparation of certificates or reports;
- testimony in court;
- services in connection with an electrocardiogram, electromyogram or

electroencephalogram, unless the physician is a specialist in the appropriate specialty;

- cosmetic surgery;
- acupuncture;
- reversal of sterilization; and
- *in-vitro* fertilization.

All residents of the Province are entitled to those insured services covered under the *Health Services and Insurance Act*. If there is the ability for a patient to purchase enhanced goods and services, such as the foldable interocular lens or a fibreglass cast, patients are required to be fully informed about the cost and are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

The Department of Health also carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

The de-insurance of insured physician services is accomplished through a negotiation process between the Medical Society of Nova Scotia and the Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Plan Regulations pursuant to section 17 of the *Health Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents. Persons moving to Nova Scotia from another country to live permanently are eligible on the date of their arrival in the Province, provided they are Canadian citizens.

Members of the Royal Canadian Mounted Police, members of the Canadian Armed Forces, federal inmates and members of the North Atlantic Treaty Organization are ineligible for MSI coverage. When their status changes, they become eligible on the first day of the third month following the month in which their eligibility status changed.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Forms must be returned to MSI with the name and mailing address of a witness (a Nova Scotia resident who can confirm that all the information on the application is correct). The application must also be accompanied by a Canadian birth certificate, a Canadian immigration certificate or other verification that the applicant is entitled to remain in Canada. If the application is complete and the eligibility criteria have been met, MSI will then issue a health card, which must be shown for each insured service received. Renewal notices are sent out from MSI to the permanent address of the resident of Nova Scotia. Upon return of a signed renewal notice, MSI will issue a new health card. Each application and health card number is unique and allocated on an individual basis.

As of March 31, 2001, the number of residents registered with MSI was 947,963.

There is no legislation in Nova Scotia forcing residents of the Province to apply for MSI. There are residents who, therefore, are not members of the health insurance plan. Failure to provide a renewal notice effectively cancels the right to service, until the resident renews.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia, once they meet the specific eligibility criteria for their situations:

Immigrants: Persons in possession of landed immigrant documents and who are referred to as permanent residents are eligible on the date of their arrival in Nova Scotia. Persons in possession of any other documents, who have applied in Canada for permanent residence status, are eligible on the date of application for permanent resident status, provided they are in possession of a letter from Citizenship and Immigration Canada.

After residing in Nova Scotia for six months, persons with employment visas are eligible for coverage retroactive to the day of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, and provided they intend to be employed in Nova Scotia for a further six months.

Work Permits: Persons moving to Nova Scotia from another country who are in possession of an employment authorization are eligible to apply for MSI on the first day of the seventh month following the date of arrival as a worker, provided they have not been absent from Nova Scotia for 31 consecutive days, except in the course of employment.

Students: Persons moving to Nova Scotia from another country who are in possession of a student authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days.

Sebaticans: Persons on employment sabbatical are treated in the same manner as all other Nova Scotia residents. Sebaticans must return to Nova Scotia within 12 months. All absences of more than the usual six months must receive prior approval before MSI coverage will be extended.

Refugees: Refugees are not insured if they are not legally entitled to remain in Canada. This includes persons awaiting a decision from Citizenship and Immigration Canada as to whether they will be permitted to remain in Canada. Refugees with work permits are governed by the eligibility provisions for persons with work permits.

As of March 31, 2001 there were 928 individuals residing in Nova Scotia who were covered under the above conditions.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents.

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services. As well, several Orders-in-Council, including MSI Regulation Order-in-Council 72-783, ensure that portability will be provided.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students temporarily absent from Nova Scotia and in full-time attendance at an educational institute remain eligible for MSI on a yearly basis, provided they supply a letter each year stating they are registered as full-time students.

Workers on work permits who leave Nova Scotia to seek employment elsewhere will remain covered by MSI for up to 12 months, provided they do not establish residence in another province, territory, or country.

Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates

in the Hospital Reciprocal Billing Agreement as well as the Medical Reciprocal Billing Agreement. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the Plan in 2000-2001 for in- and out-patient hospital services received in other provinces and territories were: $9,559,303 for out-of-province in-patient services, and $4,083,677 for out-of-province out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal billing situations.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident has not been out of the country for more than six months, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. In order to be covered, procedures of a non-emergency basis must have prior approval before they will be covered by the MSI.

Students temporarily absent from Nova Scotia and in full-time attendance at an educational institution remain eligible for MSI, provided they demonstrate registered, full-time student status.

Workers who leave Nova Scotia to seek employment elsewhere remain covered by MSI for up to 12 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent for 2000-2001 for insured in- and out-patient emergency services provided outside of Canada was $1,736,104. (Daily rate = CDN $525 per day).

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services in another province or outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a physician in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the Province, or if it can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's physician. The patient is then covered under the Reciprocal Billing Agreement for elective services in another province or territory. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions.

There are no user charges or extra charges under either plan.

No barriers to access exist in Nova Scotia.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to place emphasis on the provision of sustainable, quality health care services to its citizens.

As of March 31, 2001, 3,044 acute care hospital beds were available in Nova Scotia.

Table 1 provides a breakdown of key health professions that are licensed to practise in Nova Scotia. Not all of these health professionals were actively involved in delivering insured health services.

Table 1: Health Personnel in Nova Scotia (2000)	
Health Occupation	Registered/ Licensed to Practice[1]
Physicians	1,788[2]
Dentists	443[3]
Registered Nurses	9,327
Licensed Practical Nurses	3,349
Medical Radiation Technologists	483
Respiratory Therapists[4]	–
Pharmacists	945
Occupational Therapists	245
Speech-Language Pathologists	207
Chiropractors	52
Opticians	173
Optometrists	73
Denturists	65
Dietitians	386
Psychologists	369

1 Not all professionals licensed to practise actually work

2 Not all physicians provide services under the provincial insurance system due to the presence of Department of National Defence and Aboriginal populations

3 A limited number of licensed dentists are approved for insured dental services

4 Data not available

In Nova Scotia in 2000-2001, Telehealth was also used to provide the services listed in Table 2.

Table 2 Telehealth Services in Nova Scotia (2000-2001)	
Type of Telehealth Event	Number of "Events"
Tele-radiology Cases	14,763
Education Sessions	1,831
Clinical Consultations	729
Administrative Meetings	383
Clinical Case Conferences	281

5.3 Access to Insured Physician and Dental-Surgical Services

As of December 31, 2000, there were 1,757 physicians and 39 dentists actively providing insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

The Province has increased general practice medical training, conducts ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the Province.

5.4 Physician Compensation

The *Health Services and Insurance Act* RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between the Medical Society of Nova Scotia and the Nova Scotia Department of Health. The Medical Society of Nova Scotia is recognized as the sole bargaining agent in support of physicians in the Province. When negotiations take place representatives from the Medical Society and the Department of Health negotiate the total funding and other terms, and conditions and enhancements that the Medical Society may bring to the table in light of the fiscal restraints on the Province. Each negotiated agreement contains a provision for binding arbitration, should there be an impasse in a dispute resolution. The current master agreement negotiated April 1, 1987 and which expired March 31, 2001, contains an alternate dispute resolution mechanism.

The agreement lays out what the master unit value will be for physician services and addresses issues of stand-by or call-back compensation, members' benefit fund, Canadian Medical Protective Association funding and royalty stabilization funding. As well, there is provision for a Harmonized Sales Tax rebate. Fee-for-service is still the most prevalent method of payment for physician services. Other payment methods include hourly rate funding, hourly funding, and sessional funding.

During 2000-2001, payments for fee-for-service in Nova Scotia totalled $220,399,923. The Department paid an additional $4,766,189 for insured physician services provided to Nova Scotia residents outside the Province, but within Canada.

Payment rates for dental services in the Province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a similar process to physician negotiation. Dentists are paid on a fee-for-service basis. The current agreement expired on March 31, 2001.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine newly created District Health Authorities and the IWK Health Centre. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* was given Royal Assent on June 8, 2000. The new act instituted nine district health authorities (DHAs) that replace the former regional health boards of the Province. This change came into effect in January 2001 under the District Health Authorities General Regulations. The implementation of community health boards under the Community Health Boards' Member Selection Regulations was effective April 2001. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the Hospital Insurance Regulations define the terms for payments by the Minister of Health to hospitals for insured hospital services.

In 2000-2001, there were a total of 3,044 (3.1 per 1,000 population) hospital beds in Nova Scotia. Department of Health direct expenditures for insured hospital services' operating costs were increased to $877.02 million. Payments to out-of-province hospitals for insured services to Nova Scotia residents were $9.6 million. Total separations from all hospitals decreased slightly to 201,415.

6.0 Recognition Given to Federal Transfers

In Nova Scotia the *Health Services and Insurance Act* RS Chapter 197 acknowledges the federal contribution in respect of the cost of insured hospital services and insured health services provided to residents of the Province. The residents of Nova Scotia are aware, through press releases and media coverage of ongoing negotiations between the provinces and the federal government that Canada Health and Social Transfer (CHST) funding partially assists in the provision of insured medical services in the Province.

The Government of Nova Scotia also recognized the federal contribution under the CHST in various published documents including the following documents released in 2000-2001:

- Public Accounts 1999-2000;
- Budget Estimates 2001-2002; and
- Department of Finance Year-End Forecast.

7.0 Extended Health Care Services

These following services are not considered medically necessary and, as such, are not insured under the *Canada Health Act*.

Nursing Homes

Nursing homes in Nova Scotia provide care primarily to seniors at Level I and Level II. Level I care deals with residents in homes requiring personal care and assistance with activities of daily living. Level II care involves Level I care plus specific nursing care. This level of care is increasing dramatically as the population ages. The aging-in-place phenomenon means those seniors who were Level I are rapidly moving into Level II.

Adult Residential Care Services

Adult residential care services in Nova Scotia continue to be under the jurisdiction of the Department of Community Services and are not considered to be insured services for the purposes of the *Canada Health Act*.

Home Care Services

Home Care Nova Scotia was introduced in 1995. This program assists seniors to remain in their own homes longer, thus delaying admission to a long-term care facility. Primarily, Home Care Nova Scotia provides personal care in clients' homes along with nursing care, if required. The two major components of the program are chronic and acute patient care. The chronic component makes up approximately 80 percent of home-care clients with the remaining 15 to 20 percent being acute home care, which allows for early discharge from hospital. Home Care Nova Scotia also provides a home oxygen program. This program is still developing, and other components will be added in the future, such as occupational therapy, physiotherapy, social work, palliative care, paediatrics, and others as deemed necessary.

Nova Scotia has embarked on a single-entry access model demonstration, with plans for full implementation in April 1, 2002.

New Brunswick

Introduction

Currently there are eight Region Hospital Corporations (RHCs), established by legislation, that provide health services in New Brunswick. Each RHC includes a regional facility and a number of smaller facilities, all of which provide insured services to in- and out-patients. Each RHC has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

The population of New Brunswick is approximately 750,000, of which 33 percent is francophone. The RHCs have a mandate to deliver services to all segments of the population.

Hospital programs are divided into three general categories of complexity/resource intensity and distributed to allow the system to be as equitable as is clinically and financially feasible. Primary care in the hospital system is delivered in all facilities. Secondary care, which is specialized care requiring more sophisticated and complicated diagnostic procedures and treatment is, for the most part, found in larger facilities. More specialized services, such as nuclear medicine, would be found in the eight regional hospitals. Tertiary services are found only in a few designated centres, and in some cases these services may be designated as a provincial service. For example, the Cardiac Surgery Unit located in Region 2 (Saint John) has a provincial mandate.

The Premier's Health Quality Council was established in January 2000 to make recommendations to government on renewing New Brunswick's health system. A discussion paper was released in the spring of 2001 that aimed at forging a discussion with New Brunswickers on how to best achieve a community based, individual focused sustainable health system.

The thoughts contained in the discussion paper are preliminary and the Council has asked New Brunswickers for their opinions on the initial thoughts and directions. The input will form an important part of the final report, which is due in late 2002.

One of the recommendations is that the Province establish eight Regional Health Authority Boards as the governing bodies for eight Regional Health Authorities (RHAs). The RHAs will, with minor modifications, mirror the current health regional boundaries.

New Brunswick, like other jurisdictions, is dealing with the sustainability of its health care system. Total expenditures for the Department of Health and Wellness are approximately 28 percent of total government expenditures. The Department's budget has been increasing at a greater rate than the entire provincial budget. The Department's actual expenditures increased by 5.8 percent in 2000-2001, while provincial expenditures increased by 3.6 percent.

On April 1, 2001, the Department of Health and Wellness introduced "A Nursing Resource Strategy for New Brunswick" that will be phased in over three years. The Strategy will enhance the ability of Region Hospital Corporations to recruit and retain nurses.

Additional information may be obtained on the government website [www.gnb.ca], which has a link to the Department of Health and Wellness.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick the health care insurance plan is known as the Medical Services Plan and the public authority responsible for operating and administering the Plan is the Minister of Health and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary, and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured, and the uninsured services. The legislation also stipulates the types of agreement the provincial authority may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner, how the amounts to be paid for entitled services will be determined, how assessment of accounts for entitled services may be made, and the confidentiality and privacy issues as they relate to the administration of the Act.

The Minister of Health and Wellness is responsible for establishing a medical services plan that identifies the beneficiaries of the Plan, which services are and are not covered, and the amounts to be paid for entitled services. Under the Plan, the Minister assesses and audits physician billings through inspectors appointed by him or her and through a professional review committee as defined in sections 24(1) to 33 of the Medical Services Payment Act Regulations. The Minister also has the authority to recover the cost of entitled services against a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Public Health and Medical Services Division of the Department of Health and Wellness is mandated with the administration of the Medical Services Plan. The Minister reports either through the Department's Annual Report or through the regular legislative processes.

In February 2000, the New Brunswick government adopted a framework for Region Hospital Corporation accountability as outlined in the document *Building on our Strengths: A Framework for Region Hospital Corporation Accountability*. This document outlined the respective roles of the Department and the RHCs, and established the RHC System Planning Committee as the key process supporting RHC accountability.

1.3 Audit of Accounts

There are three groups with the mandate to audit in the area of the Medical Services Plan.

1. The Auditor General

- In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which include the financial records of the Department of Health and Wellness. For 2000-2001, all transactions of the Department were exposed to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report on identified errors and control weaknesses.

2. The Office of the Comptroller

- The Comptroller is the chief internal auditor for the Province of New Brunswick and is charged with carrying out internal audit activity in accordance with responsibilities and authority under the *Financial Administration Act*. The objective of an internal audit is to fulfill the Comptroller's mandate as it relates to Appropriations Audit, Information Systems Audit, Statutory Audits and Value-for-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited.
- No reviews were done in fiscal 2000-2001.

3. Department of Health and Wellness Internal Audit

- The Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives.

- Reviews of program areas are usually done on a cyclical basis with a major program covered once every three to four years. No reviews were performed on these programs for 2000-2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes:

- the *Hospital Services Act*, 1973, and its Regulation 86-74, section 9 of the Regulation identifies entitled services, and
- the *Hospital Act*, assented to May 20, 1992 and its Regulation 92-84.

There are eight Region Hospital Corporations, established by legislation. Each RHC includes a regional facility and a number of smaller facilities, all of which provide insured services to both in- and out-patients. Each RHC has other health facilities or health centres, without designated beds, that provide a range of entitled services to entitled persons. See Appendix 1 to this section of the report for a listing of RHC facilities by type. Note that facilities are categorized as those providing in-patient beds and those that do not provide in-patient services.

Under Regulation 84-167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured hospital services.

"*(a)* in-patient services in a hospital facility operated by an approved hospital corporation as follows:

(i) accommodation and meals at the standard ward level;

(ii) necessary nursing service;

(iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;

(iv) drugs, biologicals and related preparations, as provided for in Schedule 2;

(v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;

(vi) routine surgical supplies;

(vii) use of radiotherapy facilities, where available;

(viii) use of physiotherapy facilities, where available, and

(ix) services rendered by persons who receive remuneration therefor from the hospital corporation.

(b) out-patient services in a hospital facility operated by an approved hospital corporation as follows:

(i) laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner, where approved facilities are available;

(i.1) laboratory and diagnostic procedures together with the necessary interpretations, where approved facilities are available, when performed for the purposes of a mammography screening service that has been approved by the Minister, and

(ii) the hospital component of available out-patient services when prescribed by a medical practitioner and provided in the out-patient facility of an approved hospital corporation for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability, excluding the following services:

(A) the provision of any proprietary medicines;

(B) the provision of medications for the patient to take home;

(C) diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;

(D) visits solely for the administration of drugs, vaccines, sera or biological products; and

(E) any out-patient service which is an entitled service under the *Medical Services Payment Act*."

2.2 Insured Physician Services

The enabling legislation providing for insured physician services in New Brunswick is the *Medical Services Payment Act* (MSPA).

The MSPA was assented to on December 6, 1968. Regulation 84-29 was filed on February 13,1984, Regulation 93-143 on July 26,1993, Regulation 96-113 on November 29, 1996 and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13,1999.

No changes were introduced in 2000-2001.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions a physician must meet to participate in the New Brunswick Medical Services Plan are:

- to maintain current registration/licence with the New Brunswick College of Physicians and Surgeons;
- membership in the New Brunswick Medical Society;
- holding privileges in a Region Hospital Corporation; and
- signing the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's *Medical Services Payment Act* as of March 31, 2001 was 1,355.

Physicians in New Brunswick have the option to opt out totally or for selected services. Opted-out practitioners are not paid directly by Medicare for the services they render. They must bill their patients directly in all cases. The patients are not entitled to reimbursement from Medicare.

The opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. If an opted-in practitioner wishes to opt out for a service, then he or she must first obtain the patient's agreement to be treated on an opted-out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The practitioner must advise the patient in advance and:

a) if the charges do not exceed the Medicare tariff, the practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare;

b) if the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the service that:
   - they are opting out and charging fees above the tariff;
   - in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and
   - the patient is entitled to seek services from another practitioner who participates in the Plan.

The physician must obtain a signed waiver from the patient on the specified form and forward it to Medicare.

As of March 31, 2001 no physicians rendering health care services had elected to opt out of the Plan.

The range of entitled services under Medicare New Brunswick includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed either by a physician or by a dental surgeon in a hospital facility.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and the rest of Canada. Considerations under the term "medically

necessary" include services required for the purpose of maintaining health, preventing disease and /or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

The range of surgical-dental services under New Brunswick Medicare are payable only to oral and maxillofacial surgeons. A general dental practitioner may be paid to assist another dentist for services that are medically required to be performed in a hospital and are included in Schedule 4 of Regulation 84-20 (filed June 23, 1998) under the *Medical Services Payment Act*. Schedule 4 identifies the insured surgical-dental services that can be provided by a qualified medical practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital.

The conditions a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the New Brunswick Medicare Dental registration form).

The number of dental practitioners registered with New Brunswick Medicare is 57, although many do not provide insured services.

Dentists have the same opting-out provision as previously explained for physicians and must follow the same guidelines. The Department of Health and Wellness has no data for the number of non-enrolled dental practitioners in New Brunswick.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured Hospital Services

Uninsured services include:

- patent medicines;
- take-home drugs;
- third-party requests for diagnostic services;
- visits for the administration of drugs, vaccines, sera or biological products;
- televisions, telephones;
- preferred accommodation at the patient's request; and
- hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*.

Services are not insured if provided to those entitled under other statutes.

There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (i.e., enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.) provided in conjunction with an insured health service do not compromise reasonable access to insured services.

Uninsured Physician and Surgical-Dental Services

The services listed in Schedule 2 of the Regulation (84-20) under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

"*(a)* elective plastic surgery or other services for cosmetic purposes;

(a.01) correction of inverted nipple;

(a.02) breast augmentation;

(a.03) otoplasty for persons over the age of 18;

(a.04) removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;

(a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;

(a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract

itself, due to the existence of an illness or other complication;

(b) medicines, drugs, materials, surgical supplies or prosthetic devices;

(c) vaccines, sera, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;

(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;

(f) dental services provided by a medical practitioner;

(f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

(f.2) services that are provided in conjunction with or in relation to the services referred to above;

(h) testimony in a court or before any other tribunal;

(i) immunization, examinations or certificates for purposes of travel, employment, emigration, insurance, or at the request of any third party;

(j) services provided by medical practitioners to members of their immediate family;

(k) psychoanalysis;

(l) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;

(m) laboratory procedures not included as part of an examination or consultation fee;

(n) refractions;

(n.1) services provided within the Province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;

(o) the fitting and supplying of eyeglasses or contact lenses;

(p) transsexual surgery;

(p.1) radiology services provided in the Province by a private radiology clinic;

(q) acupuncture;

(r) complete medical examinations when performed for purposes of a periodic check-up and not for medically necessary purposes;

(s) circumcision of the newborn;

(t) reversal of vasectomies;

(u) second and subsequent injections for impotence;

(v) reversal of tubal ligations;

(w) intrauterine insemination;

(x) gastric stapling or gastric by-pass; and

(y) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility."

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary", a review of medical services plans across the country and the previous utilization of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the Government may not make any change to the Regulation until the advice and recommendation of the New Brunswick Medical Society is received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to the receipt of their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation is used.

No medical or surgical-dental services were removed from the insured service list in 2000-2001.

3.0 Universality

3.1 Eligibility

The *Medical Services Payment Act* and its Regulation 84-20, sections 3 and 4 define eligibility for the health care insurance plan.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian Immigration permit. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient or visitor to the Province.

All persons entering or returning to New Brunswick have a waiting period prior to becoming eligible for coverage. Coverage commences the first day of the third month following the month of arrival. An exception was made to grant first-day coverage for bona fide missionaries who were previously registered residents of New Brunswick at time of their departure from the country.

Residents who are ineligible include:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police;
- federal Inmates;
- persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian immigration permits. An example would be a Student Authorization.

Provisions to become eligible include:

- non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to an eligible New Brunswick resident.

Provisions when status changes include:

- persons who have been discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided they are residing in New Brunswick at the time of discharge/release, these persons are eligible for coverage on their date of release. They must complete an application, provide the official date of release/discharge and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependants under the age of 19, on a registration form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependants are registered and a Medicare card with an expiry date is then issued to the beneficiary and for each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two to three months prior to the expiry date of the Medicare card(s). A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and to sign and return the form to Medicare. Upon receipt of the completed form the file is updated and new card(s) issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are actually registered.

All family members, i.e., the beneficiary, spouse and dependants under the age of 19 are required to register as a family unit. Residents who are co-habiting, although not legally married, are eligible to register as a family unit if they so request.

The number of residents registered as of March 31, 2001 was 738,598.

Residents may opt out if they choose. They are asked to provide a written confirmation of their intention. This information is then added to their file and benefits are terminated. As of March 31, 2001, only three residents had elected to opt out of the Plan.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided they are legally married to an eligible New Brunswick resident and remain in possession of a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. In 2000-2001, approximately 50 individuals were covered under these conditions.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3 (4) and 3 (5).

Students in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another province, are granted coverage for a 12-month period that is renewable provided they:

- contact Medicare once in every 12-month period to retain their eligibility;
- do not establish residence outside New Brunswick; and,
- do not receive health coverage in another province.

Residents who are temporarily employed in another province or territory are granted coverage for up to 12 months provided they:

- do not establish residence outside the Province;
- do not receive coverage in another province or territory; and
- intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the province or territory where they are employed and should be entitled to coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all provinces and territories for the reciprocal billing of insured hospital services. As well, New Brunswick has reciprocal agreements with all provinces except Quebec for the provision of insured physicians' services. Services provided by Quebec physicians to New Brunswick patients are paid at Quebec rates, if the services are insured in New Brunswick. The majority of such claims are received directly from the Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient according to New Brunswick regulations.

During 2000-2001, New Brunswick paid to other provinces and territories:

Hospital In-patient	Hospital Out-patient	Medical
$21,561,907	$4,702,219	$7,697,923

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12-month period that is renewable provided they:

- provide proof of enrolment;
- contact Medicare once every 12 month period to retain their eligibility;
- do not establish permanent residence outside New Brunswick; and
- do not receive health coverage elsewhere.

Temporary Workers: Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12-month period, provided they do not establish residence outside the country. Any absence over 182 days, whether it be for work purposes or vacation, would require "Director's Approval". This approval can only be up to 12 months in duration and only be granted once every three years. Families will continue to be covered, provided they reside in New Brunswick.

Exception to Temporary Workers: Mobile Workers are residents whose employment requires them to travel frequently outside the Province. Certain guidelines must be met to receive Mobile Worker designation. They are:

- their applications must be submitted in writing;
- documentation is required as proof of Mobile Worker status, e.g., a letter from an employer or a photocopy of an Immigration Permit;
- permanent residence must remain in New Brunswick; and
- the person must return to New Brunswick during their off-time.

Mobile Worker designation is assigned for a maximum of three years, after which the resident must reapply and resubmit documentation to confirm status.

For teachers employed in Louisiana there is a special provision for a maximum two-year coverage.

New Brunswick Medicare covers out-of-country medical and hospital services for emergency out-patients and resulting in-patient services only. Medicare pays New Brunswick rates for physician services associated with the emergency interventions. The associated facility rates, paid in Canadian funds, are: in-patient $100 per day, and out-patient $50 per visit.

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost.

2000-2001		
Hospital In-patients	**Hospital Out-patients**	**Medical Services**
$458,759	$180,712	$362,709

4.4 Prior Approval Requirement

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided they fulfill certain requirements, which are:

- the required service(s) must be unavailable in Canada;
- it must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (Guide to United States Hospitals, Health Care Systems, Networks, Alliances, Health Organizations, Agencies and Providers);
- the service(s) must be rendered by a medical doctor; and
- the service(s) must be an accepted method of treatment recognized by the medical community and scientifically proven. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. The physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation.

The following are considered exemptions under the out-of-country coverage policy:

- haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the interprovincial rate.
- allergy testing for environment sensitivity: all tests sent outside the country will be paid at a maximum of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required for referral of patients to psychiatric hospitals and centres outside the Province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received from the referring physician(s).

5.0 Accessibility

5.1 Access to Insured Health Services

Since there are no health care user fees in New Brunswick, all residents have equal access to insured health services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds by the Region Hospital Corporation. The number of approved beds is shown in Table 1.

Table 1: Approved Beds as of March, 2001

Bed Type		Number	Percent of Total Beds
Non-Tertiary	Acute	2,878	72
	Restorative	397	10
	Addictions	174	4
	Corrections Canada	2	0
	Veterans Affairs Canada	187	5
	Sub-Total	3,638	91
Tertiary	Oncology	80	2
	Cardiac Surgery	26	1
	Neurosurgery	46	1
	Tertiary Psychiatry	206	5
	Tertiary Rehabilitation	20	0
	Sub-Total	378	9
Provincial Total		4,016	100

All facilities that provide *Canada Health Act* insured services have the appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2001 there were nine Computed Tomography (CT) scanners operating in the Province, one in each of the eight Region Hospital Corporations, with an additional unit in the Atlantic Health Sciences Corporation (Region #2). The Province also has two mobile Magnetic Resonance Imaging (MRI) units in operation, and one fixed-site MRI system.

In 2000-2001, the following initiatives served to improve access to insured hospital services in New Brunswick:

- introduction of a fixed-site MRI at the Region 1 Hospital Corporation (South East);
- Family Medicine opened a "swing unit" to reduce emergency room gridlock during winter flu season at the Region 2 Hospital Corporation;

- expansion of renal dialysis service at the Region 3 Hospital Corporation;
- expanded use and development of telehealth to improve access to services in several program areas at the Region 3 Hospital Corporation;
- the Region 6 Hospital Corporation has placed a greater emphasis on telemedicine in its patient programs;
- the Region 6 Hospital Corporation has set up an Anticoagulation Therapy Clinic; and
- the Department of Health and Wellness has established financial incentives in order to recruit and retain radiation therapists, Medical Radiation Technologists and Dosimetrists involved in providing radiation therapy services at cancer centres.

5.3 Access to Insured Physician and Dental-Surgical Services

A total of 645 family practitioners, 710 specialists, 9 dentists and 5 oral surgeons provided insured services in New Brunswick during fiscal 2000-2001.

In fiscal 2000-2001, the Department operationalized the recruitment and retention strategy aimed at attracting newly licensed family practitioners and specialists that was announced in 1999-2000. This included, in part: establishment of a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities, providing location grants of $25,000 for family practitioners and $40,000 for specialists willing to practise in hard-to-recruit areas; purchasing 10 additional seats at Memorial University Medical School, increasing government involvement in post-graduate training of family physicians, expanding the summer rural preceptorship program for medical students from 12 to 30 and moving physician remuneration toward relative parity with other Atlantic jurisdictions.

5.4 Physician Compensation

An arbitration panel awarded New Brunswick physicians a 10 percent increase for 2000-2001 and 8 percent for 2001-2002. Distribution of the wage increases has been completed, however discussions are ongoing in order to resolve outstanding issues that were not addressed by the arbitration panel.

A dispute resolution mechanism which includes mediation and binding arbitration is provided for in the Legislation.

There is no formal negotiation process for dental practitioners.

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143, 96-113.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary, and sessional or alternate payment mechanisms that may also include a blended system.

5.5 Payments to Hospitals

The primary acts of legislation governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Services Act*, which governs the financing of hospitals.

There were no changes during fiscal year 2000-2001 affecting the hospital payment process.

The Department utilizes two components to distribute available funding to the Region Hospital Corporations.

1) The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:
   - tertiary services (cardiac, dialysis, oncology);
   - psychiatric services (psychiatric units and facilities);

- dedicated programs (e.g., addiction services);
- community based services (Extra-Mural Program; health service centres); and
- general patient care.

Added to this are non-patient care support services (e.g., general administration, laundry, food services, energy, etc.).

The CSL approach establishes base budgets for the eight RHCs for the above-noted programs and services, with measures for population and service volumes. The base budgets are then adjusted annually for inflation and other factors such as centrally negotiated labour rates.

2) The population-based funding distribution formula was enhanced in 2000-2001. This methodology attempts to predict the appropriate distribution of available funding for the Region Hospital Corporations based on demographic characteristics and current market share of patient volumes, with cases measured by "Resource Intensity Weights." Currently, this methodology is more suitable to in-patient volumes because of a lack of case grouping and weighting methodologies for out-patient volumes, especially tertiary out-patient services, (e.g., oncology and haemodialysis).

The current budget process may extend over more than one fiscal year and includes several steps. By January of each year, the RHCs provide the Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current year. These, along with the audited financial statements from the prior two years, are used to evaluate the expected funding level for each RHC.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either recurring or non-recurring bases. The "year-end settlement process" reconciles the total annual approved budget for each RHC to its audited financial statements along with reconciling budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

The Province routinely recognizes the federal role regarding its contributions under the Canada Health and Social Transfer (CHST) through public documentation presented through the legislative or administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on March 27, 2001;
- the Public Accounts presented by the Minister of Finance on December 7, 2000; and
- the Main Estimates presented by New Brunswick's Minister of Finance in March 2001.

New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

The New Brunswick Long Term Care program, a non-insured service, was transferred under the Department of Family and Community Services (DFCS) on April 1, 2000. Nursing home care is also provided through the Nursing Home Services Program of DFCS. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the Province.

Residential and Extended Care Services

Table 2 identifies residential and extended-care services available in New Brunswick as of March 31, 2001. Nursing homes are private not-for-profit organizations, except for one that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities are for the most part private for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open or close residences. Clients are admitted after going through the same evaluation process used for nursing homes.

Public housing units are available for low-income elderly persons. Admission criteria are based on the age and financial situation of clients. The Victorian Order of Nurses (VON) offers support services to some units.

Table 2: Availability of Residential and Extended Care

Service	Number of Units or Beds
Nursing Home Beds	4,140
Adult Residential Facilities* (beds)	5,341
Public Housing (Units)	2,088
Provincial Total	11,569

* Includes Special Care Homes and Community Residences

Ambulatory Health Care

In New Brunswick, "ambulatory health care" includes services provided in hospital emergency rooms, day/night care in hospitals, and in clinics as may be available in hospital facilities and health centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also called the "hospital at home" program, is an active treatment program of acute, palliative and long term health care provided in community environments, (e.g., an individual's home, nursing home, or public school). The eight Region Hospital Corporations have been responsible for the delivery of the Extra-Mural Program since 1996. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists, and speech language pathologists. This service is considered an insured service under the provincial Hospital Services Plan.

Appendix 1: New Brunswick Hospital Facilities, September 2001

Hospital Corporation	Facilities Providing Insured Health Services *(Location)*	Other Facilities / Health Centres *(Location)*
Region 1 Hospital Corporation (South-East) South-East Health Care Corporation	The Albert County Hospital Inc. *(Albert)* The Moncton Hospital *(Moncton)* The Sackville Memorial Hospital *(Sackville)*	Petitcodiac Health Centre *(Petitcodiac)* Health Services, Rexton *(Rexton)*
Region 1 Hospital Corporation (Beauséjour) Corporation Hospitalière Beauséjour	Hôpital Docteur Georges L. Dumont *(Moncton)* L'Hôpital Stella Maris de Kent *(Sainte-Anne-de-Kent)*	Centre médical régional de Shédiac (Shédiac)
Region 2 Hospital Corporation Atlantic Health Sciences Corporation	Saint John Regional Hospital Facility *(Saint John)* The Charlotte County Hospital Facility *(St. Stephen)* Sussex Health Centre Facility *(Sussex)* St. Joseph's Hospital Facility *(Saint John)* The Grand Manan Hospital Limited Facility *(Grand Manan Island)* Centracare Saint John Inc. * *(Saint John)*	Campobello Health Centre Facility *(Campobello Island)* Deer Island Health Centre Facility *(Deer Island)* Fundy Hospital Association Limited Facility *(Black's Harbour)*
Region 3 Hospital Corporation	Northern Carleton Hospital *(Bath)* Queens North Health Complex *(Minto)* Oromocto Public Hospital *(Oromocto)* L'Hotel-Dieu Saint-Joseph de Perth-Andover Inc. *(Perth-Andover)* Dr. Everett Chalmers Hospital *(Fredericton)* The Tobique Valley Hospital *(Plaster Rock)* Stan Cassidy Centre for Rehabilitation * *(Fredericton)* The Carleton Memorial Hospital *(Woodstock)*	MacLean Memorial Hospital *(McAdam)* Chipman Health Services Centre *(Chipman)* Upper Miramichi Health Services Centre *(Doaktown)* Upper Miramichi Health Services Centre *(Boiestown)* Stanley Health Services Centre *(Stanley)* Fredericton Junction Health Services Centre *(Fredericton Junction)* Harvey Community Hospital *(Harvey Station)*
Region 4 Hospital Corporation	L'Hôpital régional d'Edmundston *(Edmundston)* Grand Falls General Hospital Inc. *(Grand Falls)* L'Hotel-Dieu Saint Joseph de Saint-Quentin Inc. *(Saint-Quentin)*	Centre de Santé de Ste Anne de Madawaska *(Sainte-Anne-de-Madawaska)*
Region 5 Hospital Corporation	L'hôpital régional de Campbellton *(Campbellton)* Restigouche Hospital Centre Inc. *(Campbellton)* L'Hôpital St. Joseph de Dalhousie *(Dalhousie)*	Centre de santé de Jacquet River *(Belledune)*
Region 6 Hospital Corporation Réseau Santé NOR'EST / NOR'EAST Health Network	L'hôpital régional Chaleur *(Bathurst)* Centre hospitalier de l'Enfant-Jesus inc. *(Caraquet)* Centre hospitalier de Lamèque *(Lamèque)* Centre hospitalier de Tracadie *(Tracadie)*	Centre de santé de Paquetville *(Paquetville)* Centre de santé de Chaleur *(Pointe Verte)*
Region 7 Hospital Corporation	Miramichi Regional Facility *(Miramichi)*	Baie Ste. Anne Health Centre *(Baie Ste-Anne)* Neguac Health Centre *(Neguac)* Blackville Health Centre *(Blackville)* Rogersville Health Centre *(Rogersville)*

Notes
1. "Insured Health Services" are defined in the *Canada Health Act*.
2. Addictions Services, Veterans Units, and Extra-Mural Program Units are not identified on this list.

* indicates provincial tertiary centre

Quebec

Statement from Quebec

In this report, the information pertaining to Quebec is presented in the same way as in the previous annual reports prepared by Health Canada to meet the legislative requirements that have existed since the adoption of the *Canada Health Act*.

The government of Quebec, owing to its constitutional jurisdiction in the area of health, is accountable to the National Assembly and to Quebeckers for its management of health services. In that connection, it regularly makes public various documents and reports on, among other things, the health of the population, patient satisfaction and the organization of health and social services in its territory. Most of these documents can be accessed on the Internet site of Quebec's Ministère de la Santé et des Services sociaux at www.msss.gouv.qc.ca and that of the Régie de l'assurance maladie du Québec at www.ramq.gouv.qc.ca.

Federal Response to Quebec

The Federal Minister of Health is accountable to Parliament and to Canadians regarding the monitoring of compliance by provinces and territories with the *Canada Health Act*. Section 23 of the *Canada Health Act* requires that an annual Report to Parliament be prepared by no later than December 31 of each year on the Act's administration and operation for the preceding fiscal year. The annual report is to include "all relevant information on the extent to which provincial health care plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act". The provincial and territorial governments are the source of the information required for fulfilling this statutory reporting obligation.

In 1999, the Auditor General of Canada recommended that "in its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons." In responding to the Auditor General's recommendation that *Canada Health Act* monitoring and compliance assessment activities be improved, Health Canada worked collaboratively with the provinces and territories during 2000 and 2001 to implement a standardized format for the Canada Health Act Annual Report and expanded the content to enable a better understanding of whether the *Canada Health Act* is being complied with by provinces and territories.

All provinces and territories were advised of the change in format and content requirements, including a statistical annex that provides a quantitative context for the administration and operation of the *Canada Health Act*. Officials from provinces and territories were offered technical advice and assistance in the completion of their submissions through numerous teleconferences and multilateral meetings. All provinces and territories, Quebec excepted, agreed to fulfill the revised format and content required.

Quebec

For this annual report, Quebec has provided some statistical information that is included in *Annex A – Provincial and Territorial Health Care Insurance Plan Statistics* but it is not of the type or in the manner requested. The federal government is concerned that Quebec is not providing sufficient information to effectively assess compliance with the *Canada Health Act* and satisfy the recommendations of the Auditor General. The federal government will continue to work with Quebec to ensure that information is made available to demonstrate compliance with the *Canada Health Act*.

Quebec

Public Administration

Hospital Insurance and Medical Care Plans

The hospital insurance plan, the *régime d'assurance-hospitalisation du Québec*, is administered by the Ministry of Health and Social Services, the *ministère de la Santé et des Services sociaux*.

The health insurance plan, the *régime d'assurance maladie du Québec*, is administered by the *Régie de l'assurance maladie du Québec*, a public authority appointed by the provincial government and responsible to the Minister of Health and Social Services. Both plans are operated on a non-profit basis, and all accounts and transactions are audited by the Auditor General of the Province.

Comprehensiveness

Hospital Insurance Plan

The network of establishments under the Ministry of Health and Social Services includes hospital centres, certain residential and extended-care facilities (formerly extended-care hospital centres[1]) and local community services centres.

The treatment of physical and mental illness is provided by the hospital centres, and by some of the residential and extended-care facilities.

Insured in-patient services are provided in the hospital centres, whereas out-patient services are available mainly in residential institutions and local community services centres.

Insured in-patient services include standard ward accommodation and meals; necessary nursing services; provision of routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; provision of medications, prosthetic and orthotic appliances that can be integrated to the human body, and of biological products and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital centre staff.

Out-patient services include clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery care (day surgery); radiotherapy; diagnostic services; physiotherapy; ergotherapy; inhalation, audiology and speech therapies; orthoptics; and other services or examinations required under Quebec legislation.

Other services covered by insurance are mechanical, hormonal or chemical contraception; surgical sterilization (tubal ligation or vasectomy); and reanastomosis of the fallopian tubes or vas deferens; and removal of tooth or root when the health status of the person requires or demands hospital services.

The Ministry of Health and Social Services administers an ambulance transportation program free of charge to persons aged 65 and over.

Uninsured hospital services include cosmetic surgery; *in-vitro* fertilization; private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services covered by the *Loi sur les accidents de travail et les maladies professionnelles* or other federal or provincial legislation.

[1] Since October 1, 1992, extended-care hospitals and residential facilities have been included in a single institutional category (the CHSLD—*centres d'hébergement et de soins de longue durée*), although no change has been made to their specific missions.

Medical Care Plan

The services insured by the medical care plan, the régime *de soins médicaux*, include medical and surgical services provided by physicians, as well as oral surgery performed in hospital centres or in a university facility determined by regulation by dental surgeons and specialists in oral and maxillo-facial surgery.

The following services are not considered insured: any examination or service not related to a process of cure or prevention of illness; psychoanalysis in every form, unless such service is rendered in an institution authorized by the Ministry of Health and Social Services; any service provided for purely aesthetic purposes; any refractive surgery, except in cases where there is documented failure of more than 3.00 diopters or anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn; any consultation by telecommunication or by correspondence; any service rendered by a professional to the person's spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the person who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examination, vaccination, immunization or injections given to a group or for certain purposes; any service rendered by a professional based on an agreement or a contract with an employer, an association or an organization; any adjustment of eyeglasses or contact lenses; any surgical removal of a tooth or tooth fragment carried out by a physician, except in certain cases where the service is provided in a hospital centre; all acupuncture procedures; the injection of sclerosing substances and the examination made at that time; thermography, mammography used for screening purposes, unless this service is not delivered in a place designated by the Minister in either case, either to a recipient who is 40 or over and under 50 years of age and who presents a significant risk factor associated with breast cancer, and on condition that such an examination has not been performed on the recipient in the previous two years, or to a recipient 50 years of age or older, on condition that such an examination has not been performed on the recipient in the previous two years; mammography for detection purposes, tomodensitometry, Magnetic Resonance Imaging, the use of radionuclides *in vivo* in a human, and ultrasonography, unless all these services are rendered in a hospital centre; any radiological or anaesthetic service provided by a physician if it is required with a view to dispensing an uninsured service, with the exception of a dental service provided in a hospital centre, or in case of a radiology, if it is required by a person other than a physician or a dentist; and any surgical service provided for the purposes of transsexualism unless such a service is provided upon the recommendation of a physician specializing in psychiatry and is carried out in a hospital centre recognized to this end; and any services not associated with a pathology and that are rendered by a physician to a patient between the ages of 18 and 65 years, unless that individual is the holder of a claim card for colour-blindness or a refraction problem, for the purpose of obtaining or renewing a prescription for eyeglasses or contact lenses.

In addition to the basic insured services, the *Régie* also covers, with some limitations regarding certain residents of Quebec as defined by the *Loi sur l'assurance maladie* and Employment Assistance recipients, optometric services; dental care for children and Employment Assistance recipients, and acrylic dental prostheses for Employment Assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids or other equipment for persons with physical disabilities; external breast prostheses; ocular prostheses; supplementary hearing aids and visual aids for people with visual or auditory handicaps; and permanent ostomy appliances.

Moreover, since January 1, 1997, in terms of drug insurance, the *Régie* covers over and above its regular clientele (Employment Assistance recipients and seniors 65 years and older), individuals who do not otherwise have access to a private drug insurance plan. The new drug insurance plan covers 3.2 million insured persons.

Universality

Hospital Insurance and Medical Care Plans

Registration with the hospital insurance plan is not required. Registration with the *Régie de l'assurance maladie* or proof of residence is sufficient to establish eligibility. All residents or deemed residents of Quebec must be registered with the *Régie de l'assurance maladie* to be eligible for the health insurance programs. Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police, and inmates of federal penitentiaries are not covered by the Plan. No premium payment exists.

Portability

Hospital Insurance and Medical Care Plans

Minimum Residence

Insured persons moving to Quebec from other provinces or territories in Canada are entitled to coverage under the Quebec health insurance plan when benefits under the province or territory of origin cease, provided they register with the *Régie de l'assurance maladie*.

If outside Quebec for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec in the first case for four consecutive calendar years at most, and in the second case for two consecutive calendar years at most. Quebec government civil servants, employees of non-profit organizations with head offices in Canada and employed abroad in assistance or cooperation programs recognized by the Minister of Health and Social Services, and the spouses and dependants of all such persons maintain their resident status, provided the *Régie* is notified of their absence.

This is also the case for persons living in another province for the purpose of seeking employment, holding temporary employment or working on contract, provided their families remain in Quebec or they retain a residence there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons employed or working on contract outside Quebec for a company headquartered in Quebec, or employed by the federal government and posted outside Quebec, also retain their resident status, provided their families remain in Quebec or they retain a residence there.

Resident status is also maintained by those persons who remain outside the Province for 183 days or more, but fewer than 12 months within a calendar year, provided such an absence occurs only once every seven years and is reported to the Régie.

First-day coverage is provided to certain categories of resident, notably permanent residents under the *Immigration Act*, repatriated Canadians, returning Canadians, members of the Canadian Forces and Royal Canadian Mounted Police who have not acquired their resident status, and inmates of federal penitentiaries, upon release or discharge. Immediate coverage is also provided to persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for three months or more, or who are living in Quebec under an official bursary or internship program of the Ministry of Education.

Payment Arrangements in Canada

Hospital costs incurred in other provinces or territories are paid through reciprocal billing, an interprovincial agreement established between the provinces and territories. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or high-cost procedures are paid at approved standard interprovincial/territorial rates. However, since November 1, 1995, Quebec only reimburses the average rate of Outaouais specialized centres to Ottawa hospitals when an Outaouais resident is hospitalized for non-urgent care or services available in the Outaouais.

The costs of medical services incurred in other provinces or territories are reimbursed at the amount actually paid, or the rate that would be paid by the *Régie* for the same services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when specialized services are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 for the Abitibi-Témiscamingue/North Bay area.

Payment Arrangements Outside Canada

As of September 1, 1996, hospital services provided outside Canada in cases of emergency or sudden illness are reimbursed by the Régie, usually in Canadian funds, to a maximum of $100 Canadian per diem if the patient was hospitalized (including day surgery), or $50 per out-patient visit

However, haemodialysis treatments are covered to a maximum of $220 per treatment. In such cases, the *Régie* reimburses the associated professional services. Services must be dispensed in a recognized establishment accredited as a hospital or hospital centre by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Students, unpaid trainees, Quebec officials posted abroad, missionaries and employees of non-profit organizations working under programs of international aid or cooperation recognized by the Ministry of Health and Social Services, must contact the *Régie* in order to ascertain their eligibility. If the *Régie* recognizes them as having special status, they receive full reimbursement of hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the *Régie* up to the amount of the expenses actually incurred. All services insured in the Province are covered abroad, usually in Canadian funds, at the Quebec rate.

Beneficiaries requiring medical services in hospital abroad for services unavailable in Quebec or elsewhere in Canada are reimbursed 100 percent with prior consent for medical and hospital services that meet certain conditions. Consent is not given if the hospital service is available in Quebec or elsewhere in Canada.

Permanent Moves out of the Province

Insured residents moving permanently to other parts of Canada are covered for up to three months after leaving the Province.

Coverage is immediately discontinued as of the first day that insured residents move permanently to another country.

Accessibility

Hospital Insurance and Medical Care Plans

Reasonable Access

Everyone has the right to receive adequate health care services without any kind of impediment.

There is no extra-billing by physicians in the Province of Quebec. While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration in accordance with the provincial fee schedule; and non-participating professionals who practise outside the plan entirely, so that neither they, nor their patients, receive reimbursement from the Régie.

As of March 31, 2001, Quebec counted 125 institutions operating as hospital centres for a clientele suffering from serious diseases with 21,804 acute and psychiatric care beds allotted to these institutions. From April 1, 1999 to March 31, 2000[2], hospital institutions counted more than 736,500 admissions for short-term stays and close to 78,000 registrations for day

[2] Latest year for which figures are available.

surgeries. These hospitalizations represented a total number of more than 5,555,738 patient-days.

Payment to Hospitals

The financing of a hospital centre by the Ministry of Health and Social Services is carried out through a system of payments in respect of the cost of insured services provided.

The payments transferred in 1999-2000 to institutions operating as hospital centres for insured health services for Quebec residents amounted to $5.5 billion and payments transferred to hospital centres outside Quebec amounted to approximately $73,363,000.

System of Payment for Medical Care

Physicians are paid in accordance with a negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient in accordance with the fee schedule after the patient has collected from the Régie. Non-participating physicians are paid directly by the patients according to the amount charged.

Reasonable Compensation

Provision is made in law for reasonable compensation for all insured health services rendered by health care professionals. The Minister may enter into an agreement with the organizations representing any class of professionals in the health care field, prescribing a different remuneration for medical services where the number of professionals is insufficient. The Minister may also provide a different remuneration for physicians during the first years of practice or specialty according to the territory of practice and the nature of activities. These provisions are preceded by consultation with organizations representing health care professionals.

In 2000-2001, the *Régie* had paid $2,553.1 million to doctors in the Province and the amount evaluated for medical services outside the province had reached $8.9 million.

Extended Health Care Services

Nursing home intermediate care, adult residential care and home care services are available with admission coordinated through a regional admission system and based on a single assessment tool. Local community services centres *(centres locaux de services communautaires)* receive individuals, evaluate their care requirements and either arrange for the provision of such services as day-centre programs or home care, or refer them to the appropriate agency.

Some home care services are offered by the provincial Ministry of Health and Social Services, including nursing care and assistance, homemaker services and medical surveillance.

Residential facilities and long-term care units in short-term care hospitals focus on the maintenance of autonomy and functional capacities of their clients by providing a variety of programs and services, including health care services.

Ontario

Introduction

The Ontario Ministry of Health and Long-Term Care is responsible for administering the health care system in the Province and providing services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, long-term care, home care services, community and public health, health promotion and disease prevention. The Ministry also regulates hospitals, nursing homes and long-term care facilities, operates psychiatric hospitals and medical laboratories, and coordinates emergency health services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is established under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided in hospitals and health facilities and by physicians and other health care practitioners. The health insurance plan is administered on a non-profit basis by the Ministry of Health and Long-Term Care (see section 10 of the *Health Insurance Act*).

1.2 Reporting Relationship

OHIP is a part of the Ministry of Health and Long-Term Care. Its activities and operational reports are included in general Ministry publications, including the Ministry's Annual Business Plan.

1.3 Audit of Accounts

OHIP's accounts and transactions are audited by the Provincial Auditor and are published annually in the Public Accounts of Ontario.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services in Ontario are governed by the *Health Insurance Act*, and Regulation 552 under that Act. The Act and Regulation define both in-patient and out-patient insured services.

Insured in-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations; and
- use of operating rooms, obstetrical delivery rooms and anaesthetic facilities.

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;
- use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- use of diet counselling services;
- use of home renal dialysis and home hyperalimentation equipment, supplies and medication;
- provision of equipment, supplies and medication to haemophiliac patients for use at home;
- cyclosporine to transplant patients;
- zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
- biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
- drugs for treatment of cystic fibrosis and thalassemia;

- erythropoietin to patients with anaemia of end-stage renal disease;
- alglucerase to patients with Gaucher disease;
- clozapine to patients with treatment-resistant schizophrenia; and
- the administration of a rabies vaccine.

In addition to insured hospital benefits, Ontario provides long-term care services, mental health services (including the operation of provincial psychiatric hospitals), the residential component of the Homes for Special Care Program, ambulance services (air and land) with a patient co-payment component, dental treatments for patients with cleft lip-palate who are registered at a designated clinic, and funding for a breast cancer screening program.

The *Public Hospitals Act* is the enabling legislation for public hospitals in Ontario and includes Regulation 964 on the Classification of Hospitals and Regulation 965 on Hospital Management.

In 2000-2001 there were 155 public hospital corporations (excluding specialty hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and nursing homes) staffed and in operation in the Province. This includes 140 acute care hospital corporations, 11 chronic care hospitals and 4 general and special rehabilitation units. Facilities are categorized by major activity, though they provide a mix of hospital services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation. Public hospitals may be accredited by the Canadian Council on Health Services Accreditation (CCHSA).

When insured physician services are provided in licensed facilities outside hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, the Ministry of Health and Long-Term Care provides funding through the payment of facility fees under the *Independent Health Facilities Act* (IHFA). Facility fees cover the cost of premises, equipment, supplies and personnel used to render an insured service, where these costs are not included in the physician's fee. Under the IHFA, patient charges for facility fees are prohibited.

Facility fees are to be charged only to the government by facilities that are licensed under the *Independent Health Facilities Act*. Examples of facilities that are licensed under the IHFA include surgical/treatment facilities (providing abortions, cataract surgery, dialysis, non-cosmetic plastic surgery, etc.) and diagnostic facilities (providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies). New facilities are ordinarily established through a request for proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

Under section 37(1) of Regulation 552 under the *Health Insurance Act*, a service rendered by a physician in Ontario is an insured service if it is medically necessary, referred to in the Schedule of Benefits and rendered in such circumstances or under such conditions as are specified in the Schedule of Benefits.

Physicians are registered to practise medicine in Ontario by the College of Physicians and Surgeons of Ontario. There are approximately 20,700 physicians registered to submit claims to OHIP.

Physicians may submit claims directly to OHIP for all insured services rendered to insured persons, or they may bill the insured person directly for all insured services as specified in section 15 of the *Health Insurance Act* (see also the *Health Care Accessibility Act*). Physicians who do not bill OHIP directly are commonly referred to as "opted-out". An opted-out physician bills the patient (not more than the amount payable for the service in the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. The percentage of opted-out physicians has fallen to approximately one percent since the enactment of the *Health Care Accessibility Act* in 1986.

Insured physician services in facilities, physicians' offices or in a patient's home are detailed in the Schedule of Benefits, pursuant to Ontario Regulation 552 under the *Health Insurance Act*. In general terms, these include:

- diagnosis and treatment of medical disabilities and conditions;
- medical examinations and tests;
- surgical procedures;
- maternity care;
- anæsthesia;
- radiology and laboratory services in approved facilities; and
- immunizations, injections and tests.

Services are added to or deleted (de-insured) from the Schedule of Benefits for Physician Services on the recommendation of the Central Tariff Committee of the Ontario Medical Association in consultation with the Ministry of Health and Long-Term Care. The Schedule of Benefits Working Group, comprised of members from the Ontario Medical Association and the Ministry, reviews the Schedule of Benefits on a regular basis. Public consultation may also be undertaken. Services are added to or deleted from the Schedule of Benefits for Physician Services by regulation.

2.3 Insured Surgical-Dental Services

Approximately 350 dentists and dental/oral surgeons provided insured surgical-dental services in 2000-2001.

Insured hospital surgical-dental services, prescribed in section 16 and Schedules 13, 14, and 15 of Regulation 552 under the *Health Insurance Act*, include the following where it is medically necessary that they be rendered in hospital:

- repair of traumatic injuries;
- surgical incisions;
- excision of tumours and cysts;
- treatment of fractures;
- homeografts;
- implants;
- alloplastic reconstructions; and
- all other specified dental procedures.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Insurance Act* and Regulations are insured. All other services are uninsured. Section 24 of Regulation 552 contains a non-exhaustive list of services, which are prescribed as uninsured.

Uninsured hospital services include:

- additional charges for preferred accommodation unless prescribed by a physician, oral-maxillo facial surgeon, or midwife;
- telephones and televisions;
- charges for private-duty nursing;
- cosmetic surgery under most circumstances;
- provision of medications for patients to take home from hospital, with certain exceptions; and
- in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

Uninsured physician services include:

- services that are not medically necessary;
- travelling to visit an insured person outside the area of the practice;
- toll charges for long-distance telephone calls;
- preparing or providing a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;
- advice given by telephone at the request of the insured person or the person's representative;
- an interview or case conference (in limited circumstances);
- preparation and transfer of records at the insured person's request;
- a service that is received wholly or partly for the production or completion of a document or the transmission of information to a "third party" in specified circumstances;

- the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances;
- provision of a prescription when no concomitant insured service is rendered;
- cosmetic surgery;
- acupuncture procedures;
- psychological testing;
- group screening programs; and
- research and survey programs.

The above list is not exhaustive and is subject to exceptions. Refer to section 24 of Regulation 552 under the *Health Insurance Act*, the Schedule of Benefits for Physician Services, and section 11.2 of the *Health Insurance Act*.

Furthermore, section 11.2(2) of the *Health Insurance Act* provides that services to which a person is entitled under the *Workplace Safety and Insurance Act* (1992), or under the *Homes for Special Care Act* or under any Act of the Parliament of Canada, except the *Canada Health Act*, are not insured services.

"Third-party requests" for services are not generally insured by OHIP.

Ontario's health insurance policy states that enhanced medical goods, such as fibreglass casts, are provided to the patient, without charge, where those enhanced medical goods are medically necessary.

It is a provincial offence for a physician to charge patients, or to accept payment from patients, for more than the amount payable by OHIP. A physician may charge for services that are not insured under OHIP. The Ministry does not regulate charges for uninsured services as these charges are governed by the College of Physicians and Surgeons of Ontario. The Ontario Medical Association publishes a schedule of suggested fees for uninsured services.

In 2000-2001, the Schedule of Benefits Working Group recommendations were implemented in three areas. The fee for Miscellaneous Therapeutic Procedures was de-listed from the Schedule of Benefits for Physician Services and a fee was added for Ultraviolet Light Therapy for dermatology. Hearing Aid Evaluations and re-evaluations have also been delisted from the Physicians' Schedule, and at the same time the definitions of who can perform Basic and Advanced Diagnostic Hearing Tests (DHTs) have been clarified (for payment purposes). A further change has set payment at a maximum of eight nerve blocks per patient per day for any combination of nerve blocks.

3.0 Universality

3.1 Eligibility

With certain exceptions, all residents of Ontario are eligible for coverage, subject to a three-month waiting period. Regulations under the *Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are subject to the three-month waiting period (refer to section 11(1) of the *Health Insurance Act* and Regulation 552 thereunder).

Every resident of Ontario who seeks OHIP coverage is required to register for health insurance. To be considered a resident of Ontario for the purpose of obtaining OHIP coverage, a person must:

- hold prescribed citizenship or immigration status (section 1.1(1) of Regulation 552, under the *Health Insurance Act*);
- make his or her permanent and principal home in Ontario in accordance with Regulation 552; and
- generally speaking, be physically present in Ontario for at least 153 days in any 12-month period.

With certain exceptions set out in sub-section 3(4) of Regulation 552, most new and returning residents are subject to a three-month waiting period. The Ministry will determine whether or not an individual is subject to a three-month waiting period at the time of the application. Former federal inmates and newly determined Convention Refugees are among those who are exempt from the waiting period.

Among those who are ineligible for Ontario health coverage are individuals without citizenship or immigration status as prescribed under s. 1.1 (1) of Regulation 552, federal penitentiary inmates, and refugee claimants. Persons previously ineligible for coverage but whose status has changed (e.g., change in immigration status or release from a federal penitentiary) may, upon application, be eligible for OHIP coverage subject to the requirements of Regulation 552.

There were no changes to legislation in 2000-2001 that affected client eligibility.

3.2 Registration Requirements

A health card is issued to residents upon application to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing permanent residence in the Province. Registration is done through local OHIP offices.

Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide the Ministry with proof of immigration status, residency and identity. Original documents from each category are to be provided by the applicants upon registration. Once eligibility has been determined, applicants over the age of 15½ are generally required to have their photographs and signatures captured for their photo health cards.

Each photo health card has a card renewal/expiry date in the bottom right-hand corner of the card. The Ministry mails renewal notices to registrants approximately six weeks before the card's renewal date.

The Ontario Ministry of Health and Long-Term Care is the sole payor for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service covered by OHIP.

Approximately 12,000,000 Ontario residents were registered with OHIP as of March 31, 2001.

3.3 Other Categories of Individual

Ontario's Ministry of Health and Long-Term Care provides coverage to several categories of individual other than Canadian citizens and landed immigrants. Generally, these individuals are required to provide proof of citizenship or acceptable immigration status, residency and identity in the same manner as individuals with permanent resident status who apply for Ontario health coverage. However, applicants from within these categories may also be required to provide specific documentation to confirm their entitlement to OHIP coverage or they may be exempted from certain requirements. Clients applying for coverage under any of these categories should contact their local OHIP office for details. A general overview of eligibility for applicants in other categories is included below.

The following categories of individual will be eligible if they otherwise meet the definition of resident in Regulation 552:

Applicants for Landing – Applicants for Landing are persons who are being processed toward landing by Citizenship and Immigration Canada (CIC) and, generally speaking, have met CIC medical requirements. An immigrant who has been "landed" is a permanent resident of Canada. Approximately 4,500 individuals were registered as Applicants for Landing as of March 31, 2001.

Convention Refugees – The Immigration and Refugee Board designates a person as a Convention Refugee when that person has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion. Approximately 76,400 individuals were registered as Convention Refugees as of March 31, 2001.

Minister's Permit Holders – Holders of Minister's Permits are persons who do not meet immigration requirements to remain permanently in Canada. Holders of case types 80 (adoption only), 86, 87, 88, or 89 Minister's Permits who are ordinarily residing in Ontario are eligible for OHIP coverage for the duration of their immigration documents. Holders of case type 90 Minister's Permits are not eligible for

OHIP. Approximately 800 individuals were registered as holders of eligible Minister's Permits as of March 31, 2001.

Clergy, Foreign Workers and their Accompanying Family Members – An eligible foreign clergy person is a person who is sponsored by a religious organization or denomination who has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months and who is ordinarily a resident of Ontario. Approximately 1,100 individuals were registered as eligible foreign clergy as of March 31, 2001.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer situated in Ontario and has been issued an Employment Authorization by Citizenship and Immigration Canada that names the Canadian employer, states the person's prospective occupation, and has been issued an Employment Authorization for a period of at least six months. Approximately 11,400 individuals were registered as eligible foreign workers as of March 31, 2001.

Eligible accompanying family members are the spouses and dependent children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker who is to be employed for at least three consecutive years and who is ordinarily a resident of Ontario. Approximately 7,700 individuals were registered as eligible accompanying family members as of March 31, 2001.

Migrant Farm Workers – Migrant farm workers are persons who have been issued an Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by Citizenship and Immigration Canada. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period. Approximately 2,900 individuals were registered as migrant farm workers as of March 31, 2001.

Live-in Caregivers – Live-in Caregivers are persons who have been issued an employment authorization under the Live-in Caregivers in Canada Program (LCP) or the Foreign Domestic Movement (FDM) administered by the federal department of Citizenship and Immigration. An eligible Live-in Caregiver is a person who possesses an employment authorization issued by Citizenship and Immigration Canada that indicates LCP or FDM and who is ordinarily a resident of Ontario. The employment authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers and the three-month waiting period applies to Live-in Caregivers.

3.4 Premiums

The payment of premiums was abolished in 1990.

4.0 Portability

4.1 Minimum Waiting Period

Individuals who move to Ontario and who were previously insured by another Canadian province or territory are entitled to OHIP coverage beginning the first day of the third month after establishing residency in Ontario. New or returning Ontario residents who were not previously insured by another province or territory's health plan are entitled to coverage three full months after establishing residency in Ontario.

These requirements are set out in section 3 of Regulation 552 of the *Health Insurance Act*.

4.2 Coverage During Temporary Absences in Canada

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability. In accordance with that agreement, insured residents who are outside Ontario temporarily can use their Ontario Health Cards to obtain insured health services. Insured residents who leave Ontario temporarily to

travel within Canada without establishing residency in another province or territory will continue to be covered for a period of up to 12 months.

Out-of-province services are covered under sections 28(1), 30(1) and 32 of Regulation 552 of the *Health Insurance Act*. It is also possible for Ontario residents to maintain continuous health coverage while temporarily working or studying in another Canadian province or territory.

A person insured by OHIP who seeks or accepts employment in another province or territory is provided with OHIP coverage for a maximum of 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health coverage for the duration of their studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, students should provide the Ministry with letters from their educational institution confirming registration as full-time students. Family members of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Coordinating Committee on Reciprocal Billing.

In addition, section 28 of Regulation 552 of the *Health Insurance Act* sets out payment for insured hospital services outside Ontario but within Canada that are not billed through the reciprocal arrangements.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services.

4.3 Coverage During Temporary Absences Outside Canada

Coverage during temporary absences outside Canada is governed by sections 28.1 through 31 (inclusive) of Regulation 552 of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1 (4), 1.1(5) and 1.1(6) of Regulation 552 of the *Health Insurance Act*, the Ministry of Health and Long-Term Care may provide insured Ontario residents with continuous OHIP eligibility for absences of longer than 212 days in a 12-month period. In most cases, applicants must provide the Ministry with a document explaining the reason for their absence from Ontario to qualify for an approved absence. Applicants must also have been present for at least 153 days in each of the two consecutive 12-month periods prior to the expected date of departure in order to be approved for an extended absence.

Approved absences vary in duration depending on the reason for the absence.

Reason	OHIP coverage
Study	Duration of a full-time academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/Other	Up to two years in a lifetime

Family members may also qualify for continuous OHIP eligibility while accompanying the primary applicant on an approved absence and should contact their local OHIP office for details.

Out-of-country services are covered under section 28.1 to 28.6 inclusive, and section 29-31 (inclusive) of Regulation 552 of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- a maximum $400 Canadian for in-patient services;
- a maximum $50 Canadian for out-patient services; and
- a maximum $210 Canadian per dialysis treatment.

Medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) as well as laboratory tests required on an emergency basis, are reimbursed only at the rates listed in the Ontario Ministry of Health and Long-Term Care's Schedule of Benefits, Regulation 552, or the amount billed, whichever is less. Charges for medically necessary emergency out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed hospital or health facility.

In 2000-2001 payments for out-of-country in-patient and out-patient insured hospital and medical services amounted to $34.4 million for emergency services. Prior approval for elective services is addressed in Section 4.4.

4.4 Prior Approval Requirement

Prior approval is required for payment for elective services provided outside the country. These provisions are set out in section 28.4 of Regulation 552 of the *Health Insurance Act*.

Under section 28.4 of Regulation 552, where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or cause irreversible tissue damage, the patient may be entitled to full Ministry funding of out-of-country health services.

There is no formal prior approval process for services provided to Ontario residents outside the province but within Canada. The interprovincial agreement between the provinces includes a schedule for high-cost services. In rare circumstances where this schedule does not cover the costs in another province, Ontario may be asked to guarantee payment before the service is provided.

In 2000-2001, total payments for prior approved treatment outside Canada was $27.7 million.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, medical and dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and medical services, as defined in the *Health Insurance Act*. Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured. Under the *Health Care Accessibility Act*, physicians (both opt-in and opt-out) are prohibited from charging more than the amount for an insured service than is allowed in the Schedule of Benefits for Physician Services. Extra-billing by physicians is also prohibited. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

The Ministry of Health and Long-Term Care implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to the Ministry a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are

unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 2000-2001, there were 155 public hospital corporations staffed and in operation in the Province, which included chronic, general and special rehabilitation units. There were 6,975,200 acute patient days, 2,390,403 chronic patient days and 646,839 rehabilitation patient days delivered by public hospitals during fiscal year 2000-2001.

Some examples of improved access to services are:

- introduction of first pulmonary thromboendarectomy program;
- introduction of a provincial stroke strategy that includes piloting telemedicine at three sites;
- increased cardiac and renal services through implementation of new and expanded programs;
- construction and expansion of cancer centres;
- additional medical and critical care beds to relieve pressure on emergency departments;
- addition of new long-term care beds;
- free tuition to medical students willing to practice in rural and northern areas;
- introduction of a policy to ensure emergency room patients are seen within 15 minutes;
- enhanced pre-school speech and language program;
- invested in treatment of young people with eating disorders; and
- improved access to cervical screening in remote areas.

5.3 Access to Insured Physician and Dental-Surgical Services

Reasonable access to physician services in Ontario is ensured by an adequate supply of physicians.

An Underserviced Area Program (UAP) provides residents of rural and remote areas of the Province with improved access to general physician services. Four programs enhance access to health services for residents of northern Ontario: the Northern Group Funding Plan and Community Sponsored Contracts provide alternative funding arrangements that pay a group of physicians a global amount (not fee-for-service) for primary care services, the Incentive Grant Program for physicians provides financial assistance to general practitioners and specialists locating to designated underserviced areas and the Northern Health Travel Grant financially assists patients who must travel to receive hospital and specialist medical services.

Currently, there are 100 communities in Ontario designated as underserviced by general/family practitioners and 12 communities designated as underserviced by specialists.

As of March 2001, there were approximately 20,700 active physicians, most of whom provided insured physician services in Ontario. Of this total 10,281 (49.7 percent) were family physicians and 10,392 (50.3 percent) were specialists.

Some initiatives announced in the early part of 2000-2001 to enhance access to physician services include providing free tuition and a location incentive to medical students and residents who agree to practise in underserviced areas for a minimum of three years, and an initial increase in undergraduate medical school enrolment of 40 positions for the fall 2000 academic year. This increase brings the total number of entry positions to 572 from 532 across five medical schools.

Under the Physician Outreach Program, regularly scheduled primary care clinics may be provided to remote communities which have UAP-funded nursing stations and to provide telephone back-up to the nurse/nurse-practitioners working at the nursing station.

5.4 Physician Compensation

Insured services provided by 20,500 physicians and 350 dentists in the Province are paid primarily on a fee-for-service basis, according to the Schedules of Benefits for Physician Services under the *Health Insurance Act*.

In April 2000, the Government of Ontario negotiated a four-year agreement with the Ontario Medical Association to determine funding amounts for physician services with respect to fee-for-service payments. In 2000-2001, fee-for-service physicians were paid $4.5 billion for medical, surgical and diagnostic services provided to Ontario residents.

A Schedule of Benefits Working Group, composed of Ministry of Health and Long-Term Care and Ontario Medical Association representatives, was given the mandate in the agreement to identify changes in the existing Schedule of Benefits that will result in annual savings of at least $50 million. These savings are accomplished through a mix of tightening and modernization initiatives. The first set of recommendations, projected to save $20 million annually, was implemented on August 13, 2001. The remaining $30 million in savings measures is targeted for implementation in the next fiscal year.

The Resource Based Relative Value Schedule (RBRVS) Commission was jointly established in 1997 by the Ontario Medical Association and Ministry of Health and Long-Term Care, with a mandate to recommend a relative value schedule to replace the current OHIP Schedule of Benefits on a revenue-neutral basis. A draft report assigning a new value to a selected list of over 800 services was presented to the Ontario Medical Association, Ministry of Health and Long-Term Care and relevant stakeholders on September 7, 2001 for review and feedback. Consultations with the Ontario Medical Association continue.

Representatives of government and the Ontario Dental Association negotiate agreements on adjustments to the Plan's Schedule of Benefits that cover insured dental services provided in hospital. In 1999-2000, dental expenditures were $8.1 million. The last funding agreement expired on March 31, 2000, and was extended to March 31, 2001. Discussions for a new multi-year agreement commenced in fall 2000.

5.5 Payments to Hospitals

Hospitals submit annual operating plans that are the product of a broad consultation within the facilities (all levels of staff, unions, physicians, board and so on) and within the community and region. The operating plan is first and foremost a planning document but it also has a substantial budget component, both financial and statistical. The District Health Council (DHC) and staff of the Ministry of Health and Long-Term Care then review this operating plan. The Ministry review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarification with the facility.

Payments made by the health care plan to hospitals for insured services come under the *Health Insurance Act* and are calculated on an annual budget basis. The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority programs, and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

Payments for services rendered in independent health facilities are governed by the *Independent Health Facilities Act*.

Chronic care co-payment regulations and rates are revised annually following changes in the Canada Pension Plan (CPP).

Priority programs are diverse and require highly specialized human resources and infrastructure. The programs are often high-cost and high-growth. They can be associated with newly developed treatments that include advanced therapies and technologies. Generally, these programs are managed provincially and are designed to ensure equitable access. The Ministry determines funding based on population needs and clinical outcome evidence.

Priority programs include:

- acquired brain injury;
- cancer, cardiac services;
- cochlear implants;
- cleft lip and palate dental program;
- end stage renal disease;
- genetics services (cytogenetic labs, maternal serum screening, molecular/ DNA labs);
- HIV/AIDS clinics;
- imaging (MRI);
- maternal newborn services;
- orthopaedic hip and knee implants;
- regional geriatric program;
- stroke;
- sexual assault treatment centres;
- transplants (solid organ, bone marrow); and
- trauma centres.

The Ministry measures and rewards relative cost efficiency in hospitals through the Integrated Population-Based Allocation model. Payments are made to those hospitals that spend less than expected, taking into consideration the individual characteristics of the hospital.

In addition, specialized methodologies are used for incremental funding for specific policy and program initiatives (i.e. Nursing Enhancements, 60-hour post-partum guarantee length of stay).

Funding for patient care in hospitals increased by more that $1.3 billion in 2000-2001, bringing the total funding for hospitals to over $8.7 billion in 2000-2001 from over $7.4 billion in 1999-2000.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 2000-2001 publications.

7.0 Extended Health Care Services

Extended health care, funded by the Ministry of Health and Long-Term Care, is provided by nursing homes, homes for the aged (long-term care facilities) and home-care service providers. The Ministry participates in the compliance monitoring process for long-term care facilities in many ways. It provides dietary, environmental and medical consultation services within facilities; reviews health, safety, building and dietary standards and monitors how these standards are met, and assists in the development of corrective action plans, where necessary.

Home-care services (professional services, personal support and homemaking services) are funded by the Ministry and provided through Community Care Access Centres for people of all ages. The Ministry funds attendant services for physically disabled adults and supportive housing services for seniors, physically disabled adults, adults with acquired brain injuries and persons living with HIV/AIDS. The Ministry also funds a variety of community support services such as adult day programs, meal services, and transportation services.

In addition to insured hospital benefits, Ontario provides a wide range of health services, including long-term care services; mental health services that include the operation of provincial psychiatric hospitals; community-based mental health treatment and support services; the residential component of the Homes for Special Care Program; air ambulance with a patient co-payment; dental treatments for patients with cleft lip/palate who are registered at a designated clinic; and funding for a breast cancer screening program.

Additional Materials Submitted to Health Canada

Annual Reports

- Ministry of Health and Long-Term Care Business Plan: www.gov.on.ca/health/english/pub/ministry/bplan01/bplan01.html

Audit Reports

- Ontario Health Insurance Plan 1998 (Report of Provincial Auditor): www.gov.on.ca/opa/english/e98/306.htm
- Ontario Health Insurance Plan – Follow-up 2000 (Report of Provincial Auditor): www.gov.on.ca/fin/english/budeng.htm#public

Financial Reports

- Budget Papers 2000-2001: www.gov.on.ca/FIN/english/budeng.htm#Budget
- Public Accounts 2000-2001: www.gov.on.ca/FIN/english/budeng.htm#public

Legislation

- *Health Insurance Act*
- *Health Insurance Act Regulations*
- *Public Hospitals Act*
- *Independent Health Facilities Act*
- *Health Care Accessibility Act*

Manitoba

Introduction

Health Care is a Top Priority for Manitobans

Manitoba has been nationally recognized by the Canadian Institute for Health Information as having the best plan in the country for ending hallway medicine. Through expansions to home care, better coordination of hospital resources, and the largest flu vaccination program in the Province's history, Manitoba managed to decrease the number of hallway patients by 80 percent in the year 2000.

Manitoba's five-point plan to ending hallway medicine in hospitals was introduced in 2000 and consisted of the following measures:

- opening new beds;
- improving admission and discharge procedures;
- expanding community-based services;
- strengthening prevention programs like flu immunization; and
- increasing home care and adult day-care programs.

Manitoba faces the national and global challenge of addressing a shortage of health professionals. Past failures to provide needed training resulted in staff shortages and increased waiting lists for tests and treatment. Progress is being made to redress this shortage through a range of training, recruitment and retention strategies.

Every day nurses throughout Manitoba demonstrate their commitment to the well-being of Manitobans through the professional, skilled care they provide. In turn, the Manitoba government has made a commitment to nurses in two key areas. These are:

- the recruitment of adequate numbers of nurses in a variety of areas of nursing; and
- the retention of nurses in workplaces that respect and maximize the professional skills and experience of nurses for the well-being of patients and clients.

In spring of 2000, the Manitoba government announced a five-point nursing strategy to address the concerns raised by nurses and other stakeholders within the health care system. The plan is to:

1. improve working conditions
2. increase the supply of nurses
3. increase access to continuing education
4. improve the utilization of all categories of nurses, and
5. increase nurses' input into decision making.

The Role of Manitoba Health

Manitoba Health is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Minister of Health. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for the planning and delivery of services.

It is the mission of Manitoba Health to provide leadership and support to protect, preserve and promote the health of all Manitobans. This mission is accomplished through a structure of comprehensive envelopes encompassing program, policy, and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments for insured health benefits on behalf of Manitobans related to the costs of medical, hospital, personal care, Pharmacare and other health services.

It is Manitoba Health's vision to lead the way in quality health care, built with creativity, compassion, confidence, trust and respect, empower Manitobans through knowledge, choices and access to the best possible health resources, and build partnerships and alliances for health and supportive communities.

It is also the role of Manitoba Health to foster innovation in the health care system. This is accomplished through developing mechanisms to assess and monitor quality of care, utilization and cost effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems, and alternative and less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under the *Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to the Department of Health. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical services and other health services referred to in Acts of the Legislature or Regulations thereunder. The Act was amended effective January 1, 1999 to provide for insurance with respect to out-patient services provided in relation to insured medical services provided in surgical facilities.

The Minister of Health is responsible for the administration and operation of the Plan. Under section 3(2), the Minister has the power:

> "(a) to provide insurance for residents of the Province in respect of the costs of hospital services, medical services and other health services, and personal care;
>
> (b) to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
>
> (c) to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained;
>
> (d) to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the minister considers necessary to ensure that such a consulting service is provided;
>
> (e) to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals required by the Government of Canada are submitted; and
>
> (f) in cases where residents do not have available medical and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents."

The Minister may also enter into contracts and agreements with any person or group that the Minister considers necessary for the purposes of the Act. He or she may also make grants to any person or group for the purposes of the Act on such terms and conditions as considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to have an annual report prepared, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the *Health Services Insurance Act* requires that the Provincial Auditor (or another auditor designated by the Provincial Auditor) audit the accounts of the Plan annually and prepare a report of that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 1999-2000 fiscal year and is contained in the *Manitoba Health Annual Report 1999-2000*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Sections 46 and 47 of the *Health Services Insurance Act*, as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93) provide for insured hospital services.

As of March 31, 2001, there were 98 facilities in Manitoba providing insured hospital services to both in-patients and out-patients. Hospitals are designated by regulation under the *Health Services Insurance Act*.

Services specified by regulation as insured in-patient and out-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologics and related preparations;
- routine medical and surgical supplies;
- use of operating room, case room and anaesthetic facilities; and
- use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (Regulation 49/93) made under the *Health Services Insurance Act*.

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, registered and licensed under the *Medical Act*. As of March 31, 2001, there were 2,045 physicians on the Manitoba Health Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with the *Health Services Insurance Act* and Regulations. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Prior to rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services, rendered to an insured person by a physician, that are not excluded under the Excluded Services Regulation (Regulation 46/93) under the *Health Services Insurance Act*. During fiscal year 2000-2001, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of services covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (Regulation 48/93) under the *Health Services Insurance Act*. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This regulation also provides benefits in respect of the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthdate, when provided by a registered orthodontist. As of March 31, 2001, 555 dentists were registered with Manitoba Health, of whom 105 had received payments for insured services.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and cannot charge to or collect from an insured person a fee in excess of the benefits payable under the Act or Regulations. There were no opted out providers of dental services as of March 31, 2001.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA will negotiate the fee with Manitoba Health.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured medical services include:

- examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties;
- group immunization or other group services except where authorized by Manitoba Health;
- services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants;
- preparation of records, reports, certificates, communications and testimony in court;
- mileage or travelling time;
- services provided by psychologists, chiropodists and other practitioners not provided for in the legislation;
- *in-vitro* fertilization;
- tattoo removal;
- contact lens fitting;
- reversal sterilization procedures, and
- psychoanalysis.

The *Health Services Insurance Act* states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

To de-insure services covered by Manitoba Health the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2000-2001.

3.0 Universality

3.1 Eligibility

The *Health Services Insurance Act* is the legislation that defines the eligibility of Manitoba residents for coverage under the health care insurance plan of the Province. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or a visitor, transient or tourist.

The Residency and Registration Regulation extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment, and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have an employment authorization of 12 months or more.

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

> "A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civil War Pensions and Allowances Act*; *Government Employees Compensations Act*; *Merchant Seaman's Compensation Act*; *National Defence Act*; *Pensions Act*; *Royal Canadian Mounted Police Act*; *Veterans Rehabilitation Act* or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The exclusions include residents who are members of the Armed Forces, the Royal Canadian Mounted Police and federal inmates. These residents become eligible for Manitoba Health coverage upon ceasing to be a member of the Canadian Armed Forces; a member of the RCMP; or an inmate of a penitentiary who has no resident dependants. Upon change of status these persons have one month to register with Manitoba Health (Residency and Registration Regulation, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, of their intention to be physically present in Manitoba for six months, and that they provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration certificate for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all hospital and medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for the provincial drug program.

During 2000-2001, 1,149,904 residents were registered with the health care insurance plan.

There is no provision for a resident to opt out of the Manitoba health plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation sub-section 8(1), requires that temporary workers be in possession of an Employment Authorization issued by Citizenship and

Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health coverage.

In 2000-2001, 899 individuals with Employment Authorizations were covered under the Manitoba Health Services Insurance Plan.

The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada). Five individuals were covered under Minister's permits in 2000-2001.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation, section 6, identifies the waiting period for other insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arrival in Manitoba is entitled to benefits upon the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation, subsection 7(1), defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies.

Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba upon completion of their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient high-cost procedures and out-patient services are based on national rates agreed to by provincial or territorial health plans. These include all medically necessary services as well as costs for emergency care.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 2000-2001, Manitoba Health made payments totalling approximately $16,241,775 for hospital services and $6,201,408 for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation, sub-section 7(1), defines the rules for portability of health insurance during temporary absences from Canada.

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba upon completion of their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for a period of up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational

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institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba upon completion of their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation. Hospital services received outside Canada due to an emergency or sudden attack of illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per diem rate according to hospital bed size:

- 1-100 beds: $280
- 101-500 beds: $365
- over 500 beds: $570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from their specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at no less than 100 percent of the equivalent Manitoba rate for similar services. Hospital services are paid at up to 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds.

Manitoba Health made payments totalling approximately $3,500,862[1] for hospital care provided in hospitals outside Canada in the 2000-2001 fiscal year. In addition, Manitoba Health made payments totalling approximately $500,757[2] for medical care.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for services provided in other provinces or territories. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Out-Patient Services in Surgical Facilities Regulation (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees in relation to insured medical services.

5.2 Access to Insured Hospital Services

As of March 31, 2001, Manitoba had a total of 3,993 acute care set-up beds and 703 other set-up beds (psychiatric extended treatment, palliative, chronic, long term assessment/ rehabilitation and panelled) to serve a population of 1,147,900.

Winnipeg, with 56.6 percent of the population, has 2,271 acute care set-up beds and 420 other set-up beds. In addition, there are two hospitals

[1] This figure does not include the amount paid for exchange on U.S. claims.

[2] This figure does not include the amount paid for exchange on U.S. claims paid under the Critical Shortages Fund.

that provide long term care and one adolescent psychiatric facility.

In rural Manitoba there are 1,722 acute care set-up beds and 283 other set-up beds, plus two federal hospitals and 22 federal nursing stations. In addition, rural Manitoba residents have access to Winnipeg's acute care set-up beds.

As in other provinces, Manitoba Health is experiencing a critical shortage of nurses in all geographic settings. Nursing enrolment for the University of Manitoba baccalaureate degree program has been increased and a two-year nursing diploma course has been reinstated. Manitoba does, however, have one of the higher Registered Nurse-to-population ratios in the country (89.1 Registered Nurses per 10,000 population, CIHI, 2000), but the average age of nurses is slightly higher than the Canadian average.

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields such as radiation therapy, ultrasound technology, MRI technology and lab technicians are also becoming more problematic, with difficulty recruiting for these areas. The nursing shortage is still the most critical.

Manitoba currently has access to three Magnetic Resonance Images (MRI) machines for clinical testing. All units are located in Winnipeg. The first unit was installed in 1990 by the St. Boniface Research Foundation and replaced in October 1998. The second is located at the Health Sciences Centre and became operational in September 1998. This unit was installed in conjunction with the National Research Council (NRC). The third MRI unit, located in Winnipeg, became operational in January 2000.

Manitoba has 12 Computerized Tomography (CT) Scanners – two each at the Health Sciences Centre and St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia, Seven Oaks, Grace and Concordia Hospitals. As well, there are ultrasound scanners located within Winnipeg health facilities and rural and northern regions. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

The Province has implemented a five-point plan to improve access to insured hospital services. This plan includes the provision of funding to open up to 100 new beds in Winnipeg, Brandon and Thompson; improving admission and discharge procedures such as expanded emergency fast track, increased emergency psychiatric nurse coverage, and additional geriatric program assessment teams; expanding community based services like the Community Intravenous Therapy Program, strengthening prevention programs like the flu immunization program, and increasing the capacity of the home care program and the adult day program.

Funding has been made available for the purchase of two linear accelerators to be installed in the newly redeveloped building at the McCharles site that became operational in December 2000 and June 2001. These additional machines will ensure the delivery of high quality radiation therapy. The Oncology Day/Evening Hospital was established as part of a larger effort to improve access to treatment in an appropriate care setting. This program allows cancer patients to have long and complex chemotherapy regimens in an out-patient setting.

The Breast Health Centre offers a full range of diagnostic and assessment services in one location, including diagnostic mammography and ultrasound – dedicated to breast service, stereotactic core biopsy as well as open biopsy, and surgical consultation. This centre provides individual and family education, risk assessment, screening recommendations, genetic counselling and facilitation of laboratory gene testing of women who are deemed at high risk for breast cancer, as well as referral services. Also pre- and post-operative exercises and Lymphodema treatment are provided. The interdisciplinary model of care includes the services of social workers, spiritual advisors and clinical dietitians.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2000-2001, Manitoba Health undertook several initiatives to improve access to physicians. Physician shortage in rural and remote areas of the Province is a chronic problem. Manitoba has initiated a Rural Physician Action Plan that will see improved recruitment of rural students into medicine, increased training opportunities for medical students and residents in rural communities, and strong infrastructure support for continuing medical education.

Manitoba continues to experience small increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province introduced a financial assistance grant for students and residents. In return for financial assistance during their training, the student/resident agrees to work in Manitoba for a specific period of time after graduating. The program was introduced in May 2001. The Province also introduced a new program to assist Manitoba foreign-trained physicians to achieve licensure. In return for this assistance, the physician agrees to work in an under-serviced area of the Province for a specified period of time.

5.4 Physician/Dentist Compensation

In 1998, Manitoba and the Manitoba Dental Association (MDA) entered into an Interest Arbitration Agreement. This arbitration process culminated in August 1999 when the Arbitration Board awarded an overall increase to fee-for-service remuneration of 13.4 percent, at a cost of $33.5 million, and instructed the parties to reach agreement on the specific allocation of the overall award. The allocation agreement was finalized in February 2000. The current fee-for-service agreement is effective from April 1, 1998 to March 31, 2002. The arbitration agreement continues to operate as a dispute resolution mechanism in Manitoba.

Physicians are remunerated through a combination of fee-for-service payments, alternative service arrangements, independent contracts, etc. In 2000-2001, Manitoba had no capitation arrangements in place. Dentists are compensated on a fee-for-service basis.

A memorandum of agreement is the most formal documented agreement between Manitoba Health and the MDA. Concluded in the aftermath of the above-noted major arbitration decision, the MDA memorandum ratified 13.4 percent increases for specified oral/dental/maxillofacial surgical procedures carried out in hospital facilities only. This agreement is effective for four years from April 1, 1998 to March 31, 2002.

5.5 Payments to Hospitals

Division 3.1 of the *Regional Health Authorities Act* sets out the requirements for operational agreements between Regional Health Authorities and the operators of hospitals and personal care homes, defined as health corporations under the Act.

Pursuant to the provisions of this division, authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that provides for the health services to be provided by the health corporation, the funding to be provided by the authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request the Minister of Health to appoint a mediator to assist them in resolving outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute and the Minister's resolution is binding on the parties.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire March 31, 2006. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other regional health

authorities that continue to have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or the federal government. The agreements in place between the Authorities and the health corporations do not have expiry dates and the Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by regional health authorities for the provision of hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health and Social Transfer in public documents. Manitoba does not advertise or produce promotional material concerning insured or extended health services.

7.0 Extended Health Care Services

Manitoba has established community based service programs as an appropriate alternative to hospital services. These service programs are provided by Manitoba Health through the Regional Health Authorities. These services include the following.

Personal Care Home Services

The Personal Care Services Insurance and Administration Regulation under the *Health Services Insurance Act* authorizes the provision of services to personal care home residents. Both proprietary and non-proprietary homes are licensed in the Province of Manitoba by Manitoba Health. Residents of personal care homes also pay a residential charge. The total Manitoba Health operating expenditures for personal care services during fiscal year 2000-2001 amounted to $347,695,900, supporting a total of 9,791 licensed set-up personal care beds. In addition, there were estimated capital and equipment expenditures of $40,135,900.

Home Care Services

Manitoba Home Care is a province-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs.

Ambulatory Health Care Services

The *Health Services Insurance Act* includes a provision authorizing the designation of non-profit publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act. There are approximately 10 such institutions receiving funding from Manitoba Health.

Adult Residential Care Services

Residential care facilities are community based facilities that provide board and room, 24-hour on-site care and supervision, and assistance with activities to ensure that the needs of individual residents are met. These facilities are classified by size: approved homes have up to three adults, and licensed facilities have occupancies of four or more adults.

Residential care facilities are required to be licensed under the *Social Services Administration Act* and Manitoba Regulation 484/88R and to meet standards established by the Residential Care Licensing Branch of the Department of Family Services and Housing. The regulations mandate the licensing of facilities for three adult disability categories (mentally ill, mentally disabled, and infirm aged).

There are currently 98 licensed and approved residential care facilities for individuals with mental illness in Manitoba, for a total of 472 bed spaces. There are also 71 mixed facilities for a total of 208 bed spaces. There are 20 licensed and approved facilities for individuals with infirmities of aging, for a total of 217 bed spaces. The majority of residential care facilities are located in Winnipeg and Brandon.

Saskatchewan

Introduction

The health system in Saskatchewan, as elsewhere in Canada, exists within an intricate relationship of federal, provincial and local government initiatives, private and public funding and provision of service, and with the support and leadership of a large and diverse number of dedicated health professionals.

Saskatchewan is the birthplace of Medicare. Insured hospital services were first provided in Saskatchewan in 1947 and insured physician services were first provided in Saskatchewan in 1962. The primary principle underlying Medicare is that health services should be provided to individuals based on health need rather than on the ability to pay.

Today, the public health system provides a wide range of hospital, physician, public health, mental health, rehabilitation and addiction services to residents in Saskatchewan without any direct service charge. The provincial government also contributes to a range of home care, ambulance, pharmaceutical, special care homes and other specialized services with some level of patient co-payment. These services are delivered through district health boards, affiliated agencies, fee-for-service physicians, pharmacists, and other health care providers. The provincial government, as the major funder of Saskatchewan's health care system, is a major driver in this sector.

In Saskatchewan, District Health Boards have been established to assess needs and to plan and deliver a specific range of integrated health services within designated regions, including hospital services, home care, public health, long-term care, and promotion, protection and prevention services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and dental-surgical services in Saskatchewan.

Section 6.1 of *The Department of Health Act* (1978) authorizes the Minister of Health to:

- pay part of or the whole of the cost of providing health services for any persons or classes of person that may be designated by the Lieutenant Governor in Council;
- pay part of or the whole of the cost of providing health services in any health district or part of a health district in which those services are considered by the Minister to be required; and
- make grants or provide subsidies to any health agency as the Minister considers necessary.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998), also known as *The Medical Care Insurance Act*, provide authority for the Minister of Health to establish and administer a plan of medical care insurance for residents.

The Health Districts Act (1993) provides authority for the Lieutenant Governor in Council to establish District Health Boards (section 3) and for District Health Boards to provide services (section 26). Thirty-two District Health Boards have been established to provide insured hospital services and a range of other health services.

Sections 5 and 11 of *The Cancer Foundation Act* (1997) provide for the establishment of a Saskatchewan Cancer Foundation and for it to coordinate a program for the diagnosis, prevention and treatment of cancer.

The mandates of the Department of Health, District Health Boards, and the Saskatchewan Cancer Foundation are outlined in *The Department of Health Act*, *The Health Districts Act* and *The Cancer Foundation Act* as described above.

1.2 Reporting Relationship

The Department of Health is directly accountable to and reports to the Minister of Health on an ongoing basis with regard to the funding and administration of funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report of the medical care insurance plan to the Legislative Assembly.

The Health Districts Act prescribes that a District Health Board shall, within three months after the end of each fiscal year, submit to the Minister of Health:

- a report of the District Health Board's service activities and costs;
- a detailed audited set of financial statements;
- a report on the health status of the residents of the health district; and
- a report on the effectiveness of the District Health Board's programs.

All District Health Boards are required to annually submit three-year strategic plans and annual budget plans to Saskatchewan Health.

District Health Boards also consult with staff from Saskatchewan Health on an ongoing basis about matters of concern to either the District Health Board or the Minister of Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report to the Minister of Health for the immediately preceding fiscal year, about its business and a financial statement.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to District Health Boards, the Saskatchewan Cancer Foundation and to physicians and dental surgeons for insured physician and dental-surgical services. The Provincial Auditor may also carry out audits of District Health Boards. The Provincial Auditor independently determines the scope and frequency of its audits based on accepted professional standards.

Section 36 of *The Health Districts Act* prescribes that the accounts of a District Health Board shall be audited at least once in every fiscal year by an independent auditor who possesses the prescribed qualification and is appointed for that purpose by the District Health Board. A detailed audited set of financial statements must be submitted annually by each District Health Board to the Minister of Health.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated person.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Department of Health Act (1978) provides for the Department of Health to administer health-related acts (section 5) and outlines the powers and duties of the Minister of Health (section 6), including the powers to pay the costs of health services and to fund organizations providing health services.

The Health Districts Act (1993), provides for the establishment of District Health Boards to plan and manage the provision of health services and authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act, and to enter into agreements with District Health Boards respecting grants made pursuant to the Act or, any other matter related to the activities or affairs of a District Health Board.

The Saskatchewan Hospitalization Regulations were repealed in 2000-2001, as they were no longer applicable after the enactment of *The Health Districts Act*. The Regulations concerned the taxation of residents for hospital services and payments to hospitals. Funding for hospitals is now included in funding provided to the health districts.

As of March 31, 2001, the following numbers and types of facilities were providing insured hospital services to in-patients and out-patients:

- sixty-eight acute care hospitals provided in-patient and out-patient services; and
- one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

The Hospital Standards Act and *The Hospital Standards Regulations* (1980), establish minimum standards for care and certain administrative requirements for hospitals. All hospitals must provide facilities for the provision of treatment services to in-patients and out-patients, and must have diagnostic services, x-ray and darkroom space, and a pharmacy to facilitate adequate and accurate dispensing of drugs. At least one member of the medical staff must reside in the community in which the hospital is located. Every hospital must employ at least three full-time Registered Nurses, one of whom shall be the Director of Nursing, and shall ensure that there is at least one Registered Nurse on duty on each shift.

The Hospital Standards Act also provides for appointment by the Minister of one or more inspectors to inspect and report on facilities approved under the Act (section 12). *The Hospital Standards Regulations* (section 103) include the provision that "every hospital may be visited at any time by the Minister, an inspector or any person authorized by the Minister to ensure compliance with the Act and these regulations."

The Department encourages and supports health districts to obtain district-wide accreditation from the Canadian Council on Health Services Accreditation (CCHSA). CCHSA is the major national accrediting body for organizations across all health sectors in Canada. The accreditation process evaluates all aspects of health services delivery from a client-centred perspective. Participating health districts assess and compare their organization against national quality standards so that they may achieve coordinated, responsive and appropriate programs for all residents. There are currently 30 health districts that participate in the CCHSA accreditation process.

A comprehensive range of insured services is provided by hospitals, which may include:

- public ward accommodation;
- necessary nursing services,
- the use of operating room and case room facilities;
- required medical and surgical materials and appliances;
- x-ray, laboratory, radiological and other diagnostic procedures;
- radiotherapy facilities;
- anaesthetic agents and the use of anaesthesia equipment;
- physiotherapeutic procedures;
- all drugs, biological and related preparations administered in hospital; and
- services rendered by individuals who receive remuneration from the hospital.

No registry or central listing is maintained of the full range of services provided by Saskatchewan hospitals (e.g., no listing is maintained of all nursing services, laboratory, radiological and diagnostic procedures).

District Health Boards have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available funding resources.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998) provide for the Minister of Health to establish and administer a plan of medical care insurance for provincial residents.

Amendments were made in April 1999 and January 1, 2001, to the Physician Payment Schedule of *The Saskatchewan Medical Care Insurance Payment Regulations* in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services and changes in payment levels for selected services.

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra-billing for insured services.

As of March 31, 2001 there were 1,609 physicians licensed to practise in the Province and eligible to participate in the medical care insurance plan. This increase over previous years is partly the result of including locum registrations previously excluded from the active physician counts.

Physicians can opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2001 there were no "opted out" physicians in Saskatchewan.

Insured physician services are those services that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of *The Saskatchewan Medical Care Insurance Regulations* of *The Saskatchewan Medical Care Insurance Act*.

There were approximately 3,000 different insured physician services as of March 31, 2001.

Insured physician services are added to the Medical Services Plan through a process of formal discussion with the Saskatchewan Medical Association. The Executive Director of the Medical Services Branch manages the process of adding a new service. When a new insured physician service is covered by the Medical Services Plan, a regulatory amendment is made to the Physician Payment Schedule. No new services were added in 2000-2001.

Formal public consultations are not held about adding an insured physician service, although any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan.

Ninety-two dental specialists were providing such services as of March 31, 2001.

Dentists are able to opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

As of March 31, 2001 there were no "opted out" dentists in Saskatchewan.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- oral surgery required in hospital as a result of trauma;
- treatment for infants with cleft palate;

- hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
- surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with the dental surgeons of the Province. The Executive Director of the Medical Services Branch manages the process of adding a new service. Formal public consultations are not held about adding an insured surgical-dental service although any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

- in-patient and out-patient hospital services provided for reasons other than medical necessity;
- the extra cost of private and semi-private hospital accommodation not ordered by a physician;
- physiotherapy and occupational therapy services not provided by or under contract with a District Health Board;
- services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
- non-emergency cataract and non-emergency Magnetic Resonance Imaging services provided outside Saskatchewan without prior written approval;
- non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- non-medically required elective physician services;
- surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
- services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with District Health Boards, physicians and dentists.

There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with District Health Boards, physicians and dentists.

Insured hospital services could be de-insured by the Government if determined no longer medically necessary. The process is based on discussions among District Health Boards, clinicians and officials from the Department of Health.

Insured surgical-dental services could be de-insured if determined not medically necessary or not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the Province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if determined not medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2000-2001.

3.0 Universality

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and *The Medical Care Insurance Beneficiary and Administration Regulations* define eligibility for insured health services in Saskatchewan.

Eligibility is limited to residents. "Resident" means a person who is legally entitled to remain in Canada, makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor in Council to be a resident.

Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following their establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for coverage for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police, federal inmates; refugee claimants; and Kosovar Refugees who are covered under the Interim Federal Health Program;
- visitors to the Province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the Royal Canadian Mounted Police, if stationed in or resident in Saskatchewan on discharge date;
- released federal inmates;
- refugee claimants, on receipt of Convention Refugee status (immigration documentation is required); and
- Kosovar Refugees, on expiration of their coverage under the Interim Federal Health Program (immigration documentation is required).

3.2 Registration Requirements

The following registration process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident other than a dependent child under 18 years of age is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina or Saskatoon or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire December 2002.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 years of age and over living in the parental home or on their own must self-register.

The number of persons registered in Saskatchewan on June 30, 2000 was 1,021,762.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of either an Employment Authorization, Student Authorization or Minister's Permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with either an employment/student authorization, Minister's permit or permanent resident, i.e., landed immigrant record.

As of March 31, 2001, there were 3,604 such temporary residents in Saskatchewan.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency in Saskatchewan. However, where one spouse arrives in advance of the other, the eligibility for the first arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the third month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* of *The Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents when temporarily absent within Canada.

Continued coverage for a resident during such a period of temporary absence from Saskatchewan is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized education facility (written confirmation by Registrar of the full-time student status is required annually);
- employment: up to 12 months (no documentation required); and
- vacation and travel: up to 12 months.

Section 6.6 of *The Department of Health Act* replaces the previously noted section 14 of *The Saskatchewan Hospitalization Regulations* as providing the authority for payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the Province.

Section 10 of *The Saskatchewan Medical Care Insurance Payment Regulations* provides for the payment of physician services to Saskatchewan beneficiaries temporarily residing outside the Province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates.

In 2000-2001 expenditures for insured out-of-province physician services were $13.77 million and insured out-of-province hospital services were $28.68 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* of *The Medical Care Insurance Act* describe the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on expiration of the approved period as follows:

- students: for the duration of studies at a recognized education facility (written

confirmation by a Registrar of full-time student status is required annually);

- employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day. Section 6.6 of *The Department of Health Act* replaces the previously noted section 15 of *The Saskatchewan Hospitalization Regulations* regarding provision of health coverage to Saskatchewan beneficiaries temporarily residing outside the Province.

In 2000-2001, $1,022,000 was paid for in-patient hospital services and $377,600 was spent on out-patient hospital services.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

The reciprocal arrangement for physician services applies to every province except Quebec. Physician bills are submitted and Saskatchewan Health pays for insured services provided in Quebec at Saskatchewan rates. However, the physician fees will be paid at Quebec rates with prior approval.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health and problem gambling services;
- cataract surgery services, bone densitometry, and Magnetic Resonance Imaging (MRI), since Saskatchewan Health doesn't normally cover these services out-of-province.

Before the Department of Health funds services received by a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada.

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring physician must ask for prior approval from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.
- Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric, and chiropractic services; therefore, prior approval is required.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in the provision of public services, which include insured health services, on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2001, Saskatchewan had 3,307 staffed hospital beds in 68 acute care hospitals, including 2,802 acute care beds, 203 psychiatric beds and 302 other beds.

The Wascana Rehabilitation Hospital had 118 rehabilitation beds, 109 extended care beds and 80 other long-term care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

The Department does not collect information on acute care beds used for out-patient services.

Province-wide data from the Provincial Health Employer Survey shows that throughout the 1990s, there was small but steady growth in the numbers of health professionals employed in the provincial health system. In almost all cases, the number of practising health professionals in the Province increased throughout the last decade. There were, however, decreases in the number of Registered Nurses (about 6.5 percent) and Licensed Practical Nurses (about 19 percent) over this period. Saskatchewan's population has not changed substantially over this period, although the proportion of the population aged 75-plus increased from 5.9 percent to 7.3 percent of the covered population.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2000, the ratio of Registered Nurses to population in Saskatchewan (835/100,000) was similar to other provinces and higher than the rate for Canada as a whole (754/100,000).

In the past two years, hospitals have experienced shortages of nursing staff, particularly nurses with specialized training to work in areas such as operating rooms, intensive care and dialysis.

Listed below are some of the initiatives implemented to improve the recruitment and retention of nurses.

- In fall 2000, 280 students enrolled in the first year of the Nursing Education Program of Saskatchewan (RNs and RPNs), an increase of 100 over the previous year.
- In April 2000, the Province announced a bursary program for RNs, LPNs and RPNs who wished to re-enter their respective professions.
- In July 2000, a principal nursing advisor for Saskatchewan was appointed to provide advice and expertise to the Minister and Deputy Minister on policy and program issues pertaining to nursing, as well as working with health professionals, employers, professional regulatory bodies and unions to address nursing issues.
- Other initiatives include pilot projects to create "magnet" work environments, address issues of casual workforce in specific nursing units (e.g. sick time, hiring practices and overtime costs), and mentoring nursing students during clinical assignments.

With regard to the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- Magnetic Resonance Imaging (MRI) machines are located in Saskatoon (2) and Regina (1);
- Computed Tomography (CT) scanners are available in Saskatoon (3), Regina (3), Prince Albert (1) and Swift Current/Moose Jaw (1);
- renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton and Swift Current;
- cancer treatment is provided at clinics in Saskatoon and Regina. More than 46,000 cancer treatments are given to an average of 4,500 patients at the Saskatoon and Regina Cancer Clinics every year;
- nineteen health districts are involved in a Community Oncology program that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon;
- approximately 70 percent of surgery services are provided in Saskatoon and Regina where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 22 percent is provided in five mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current and North Battleford, with the remaining surgery performed in smaller hospitals across the Province; and

- telehealth links have been established to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2000-2001 to improve access to insured hospital services.

- Access and use of specialized medical imaging services including MRI, CT and bone mineral density testing has grown steadily in Saskatchewan during 2000-2001. In that year, approximately 12,000 MRI tests were performed, representing a 30 percent increase from the previous year; approximately 62,000 CT tests were performed, representing a 15 percent increase from last year and double the volume of 1992-93.
- In October 2000 the Regina district began providing a bone mineral density testing service in order to serve residents in southern Saskatchewan. Previously, the Saskatoon district was the sole provider of this service in the Province.
- On June 30, 2000 the 12-month Northern Telehealth Network (NTN) pilot project was completed. The NTN is a partnership between Saskatchewan Health and six health districts. An external evaluation concluded that the network improved access to services for patients and clients, particularly for child psychiatry and dermatology patients. The number of specialist clinics held in the north has remained stable, which means that the NTN has increased access to specialists without increasing their travel.
- The NTN has proved to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health will continue to support the network, and in the 2000-2001 fiscal year applied to Health Canada for funding under the Canadian Health Infostructure Partnership Program (CHIPP) to further develop this program in the rest of the Province.
- The Saskatchewan Cancer Agency continued to expand the Community Oncology Program, and 19 health districts now participate. This Program allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon. An evaluation of the Program was expected to be finalized in the fall of 2001.
- Saskatchewan Health contributed $4.2 million toward the purchase of a new linear accelerator and treatment planning system for the Allan Blair Cancer Centre in 2000-2001. Construction of a bunker to house the new treatment equipment began in April 2001 and the new linear accelerator is scheduled to be installed and operational by Spring, 2002.
- Increased funding was provided to expand the peripheral blood stem-cell transplant program for cancer patients to include myeloma and leukemia patients, following the Program's success in the treatment of Hodgkin's Lymphoma and Non-Hodgkin's Lymphoma. The expansion of this specialized service ensures that more cancer patients can be effectively treated closer to home, reducing the financial and emotional burden of travelling long distances to receive treatment. Since the inception of the program in 1998, 112 patients have been referred to the Stem Cell Program.
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven stationary sites around the Province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program has the highest participation rate in Canada, with approximately 36,400 women screened annually.

Saskatchewan Health has dedicated considerable time and resources to resolving the wait-list issue. Guided by the recommendations of the Task Team on Surgical Waiting Lists (March 1999), the Department has continued to work with all health sector partners to improve access to surgical services in the Province.

The provincial government established a $12 million wait-list fund in August 1999 to address wait-list issues and reduce waiting times for insured services. In 2000-2001, this fund was expanded to include Prince Albert and Moose Jaw, while investments continued in Saskatoon

and Regina. The funds were used by the four largest health districts to:

- purchase additional capital equipment for surgery;
- increase available operating room time through staff scheduling changes and moving some procedures out of operating rooms to ambulatory care;
- fund staff recruitment, retention and training initiatives; and
- implement a series of coordination and utilization management initiatives.

In 2000-2001, Saskatchewan Health continued to take part in the Western Canada Waiting List Project along with 19 partner organizations from the four western provinces. The Project worked closely with physicians, the public, regional health authorities and governments to develop and test clinical assessment tools. These tools will help physicians consistently prioritise patients waiting for total hip or knee replacement, cataract surgery, general surgery, children's mental health services, and diagnostic MRI scans.

5.3 Access to Insured Physician and Dental-Surgical Services

As of March 31, 2001 there were 1,609 active physicians (defined as earning at least $10,000 per quarter in fee-for-service earnings) in Saskatchewan. Of these, 1,016 (63.1 percent) were family practitioners and 593 (36.9 percent) were specialists.

As of March 31, 2001 there were approximately 398 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety-two provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2000-2001 to enhance access to insured physician services and reduce waiting times.

- A new Long-term Service Retention Program will reward physicians who work in the Province for 10 or more years.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- New Specialist Recruitment and Retention Funding provides funding for new initiatives in addition to the existing funding of the Regina and Saskatoon Health Districts.
- A Physician Recruitment Coordinator is assisting rural districts and physicians in recruiting physicians.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program through which $6.8 million in annual funding is used to compensate physicians providing emergency room coverage in rural areas, and to assist those communities with fewer than three physicians to gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Program makes grants of $18,000 available to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Medical Resident Bursary Program provides bursaries of $18,000 to three family medicine residents to assist them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $18,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- The Rural Emergency Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are

required to provide service in rural Saskatchewan after completing an educational program.

- The Resident Weekend Relief Program matches second-year family medicine residents with physicians in larger rural communities who are seeking weekend relief.
- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program, while they take vacation, education or other leave.
- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to assist in stabilizing the supply of physicians in northern Saskatchewan.
- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the Government providing notice to commence discussion on a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn selects a third member; and
- the Board has the authority to make a binding decision on the parties.

In December 2000 a new three-year agreement (retroactive to April 1, 2000) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of three percent in each year of the contract. Similar increases were applied to non fee-for-service physicians. Increased funding was also provided for new items and modernization of the payment schedule.

Section 6 of *The Saskatchewan Medical Care Insurance Payment Regulations* outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services.

5.5 Payments to Hospitals

Saskatchewan adopted a population needs-based funding approach in 1994 and 1995. Through this approach, funding is allocated to each District Health Board on the basis of population characteristics determining service needs. Each District Health Board is given a global budget defined by broad service sector (e.g., institutional acute care hospitals;

institutional supportive care; home-based services), and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes. Districts may receive additional funds for the provision of specialized hospital programs, (e.g., renal dialysis, specialized medical imaging services and specialized respiratory services) or for the provision of services to residents from other health districts.

Payments to health districts for delivering services are made pursuant to *The Health Districts Act* (1993). The legislation provides authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act and to enter into agreements with District Health Boards respecting grants made pursuant to the Act or any other matter related to the activities or affairs of a District Health Board.

District funding, including the bulk of funding for insured hospital services, is provided through the needs-based funding approach described above.

Districts may be given additional funds for providing specialized hospital programs, such as renal dialysis, specialized medical imaging services and specialized respiratory services.

Designated funds to address surgical waiting list issues were provided to the four largest health districts in 2000-2001. Each district was asked to outline a maximum expenditure on capital equipment and a plan for allocating equipment, with the remainder of the allocated funds to be spent on operational initiatives to increase surgical capacity and throughput. Districts were required to report all expenditures and changes in service volumes resulting from the additional funding.

District Health Boards provide an annual report on the aggregate financial results for their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in the Department of Health 2000-2001 Annual Report, the 2000-2001 Annual Budget and related budget documents, its 2000-2001 Public Accounts, and the Mid-Year Financial Report. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums (see Additional Materials section).

7.0 Extended Health Care Services

As of March 31, 2001, the range of extended health care services provided by the provincial government included a prescription drug plan, the Saskatchewan Aids to Independent Living Program, which provides medical equipment and appliances to disabled persons; the Supplementary Health Program, which provides non-insured health services to people nominated by Saskatchewan Social Services; the Family Health Benefits Program, which provides non-insured health services primarily to children of low-income working families; a children's dental education program; a hearing aid program; partial coverage for services provided by chiropractors, optometrists and chiropodists; home care services; long-term care services; air and road ambulance services; community clinic and community health centre services; addiction services; mental health services; occupational and physical therapy.

Nursing Home Intermediate Care Services

- Special-care homes provide institutional long-term care services to meet the needs of individuals with heavy care needs. Services offered include care and accommodation, respite care, day programs, night care, palliative care, and in some instances convalescent care. These facilities are publicly funded through the District Health Boards and are governed by *The Housing and Special-care Homes Act*.
- Public Health Services of District Health Boards provide immunization to residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services of District Health Boards who then provide them to local long-term care and other similar residential facilities. This applies to influenza and pneumococcal vaccines.

Adult Residential Care Services

Mental Health Services

- Group homes provide 24-hour living assistance to individuals with long-term mental illnesses and are governed by *The Mental Health Services Act* and *The Residential Services Act*.
- Saskatchewan Health, in partnership with the Midwest Health District, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and is currently governed by *The Non-profit Corporations Act* and *The Co-operatives Act*.

Alcohol and Drug Services

- Alcohol and drug services generally fall under *The Health Districts Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the Health Districts contract with community based and non-profit organizations to provide services governed by *The Non-profit Corporations Act*.
- Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days. *The Housing and Special-care Homes Act* governs detoxification services.
- In-patient services are provided to individuals who are concerned about their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs. In-patient services are governed by *The Housing and Special-care Homes Act*.
- Long-term residential services provide services for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse prevention in a safe and supportive environment. *The Housing and Special-care Homes Act* governs long-term residential services.

Home Care Services

- The Home Care Program provides an option for those individuals with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals that have palliative, acute and supportive care needs. Services include assessment/care coordination, nursing, personal care, respite, homemaking, meals, home maintenance, therapy and volunteer services. This program is governed by *The Home Care Act* (in the process of being repealed) and *The Health Districts Act*.

Ambulatory Health Care Services

- Saskatchewan Health Districts provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act*.
- Most Saskatchewan Health Districts offer chiropody services. Services include assessment, consultation and treatment. This program is governed by *The Health Districts Act*.
- Saskatchewan Health Districts also offer a Hearing Aid Program. Services include hearing screenings, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Health Districts Act* and *The Speech-Language Pathologists and Audiologists Act* govern these programs.
- Community therapies, including occupational and physical therapies, are offered by the Saskatchewan Health Districts and help individuals of all ages to improve their functional independence. Services are provided in facilities, schools, hospitals, and private homes and include assessment, consultation and treatment. *The Health Districts Act* governs this program.

Additional Materials Submitted to Health Canada

- Saskatchewan Health Annual Report, 1999-2000
- Medical Services and Health Registration Branch Annual Report, 1999-2000
- Saskatchewan Finance Backgrounder – 2001-2002 CHST
- Partners in Health – Our Other Partners
- Health Services Opportunities Conference – November 25, 2000, Speaking Notes for the Minister of Health
- *The Non-profit Corporations Act*, 1995
- *The Speech-Language Pathologists and Audiologists Act*
- The *Home Care Act*
- *The Co-operatives Act*, 1996
- *The Cancer Foundation Act*
- *The Housing and Special-care Homes Act*
- *The Mental Health Services Act*
- *The Residential Services Act*
- *The Housing and Special-care Homes Regulations*
- *General Regulations under The Cancer Control Act*
- *The Dental Care Beneficiary Regulations, 1987*
- *The Dental Care Act*
- *The Hospital Standards Act*
- *The Hospital Standards Regulations, 1980*
- *The Department of Health Act*
- *The Saskatchewan Medical Association Dues Check-off Regulations, 1996*
- *The Saskatchewan Medical Care Insurance Act*
- *The Optometric Services Payment Negotiation Regulations, 1988*
- *The Medical Care Insurance Peer Review Regulations*
- *The Chiropractic Services Payment Negotiation Regulations*
- *The Insured Services (Physicians) Payment Schedule Review Regulations, 1989*
- *The Insured Services (Physicians) Access Regulations, 1987*
- *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*
- *The Medical Care Insurance Beneficiary and Administration Regulations*
- *The District Health Boards Election Regulations*
- *The Health Districts Act*
- Saskatchewan Budget 2000-2001 and 2001-2002 at www.gov.sk.ca/finance/budget
- Public Accounts 2000-2001 at www.gov.sk.ca/finance/paccts/default.htm

Alberta

Introduction

The Ministry of Alberta Health and Wellness (AHW) includes the Department of Health and Wellness (the Department) and the Alberta Alcohol and Drug Abuse Commission (AADAC). The Department consists of six divisions and 28 branches.

Mission:

The mission of the Ministry is to lead and support a system for the delivery of quality health services and to encourage and support healthy living. The vision of the Department is "Citizens of a Healthy Alberta Achieving Optimal Health and Wellness".

In addition to the principles described in the *Canada Health Act*, the Department is committed to providing a health system that:

- demonstrates excellence. High standards and best practices are achieved through research, education and information;
- provides for equal access by all Albertans to a comprehensive range of integrated health services;
- provides quality services and effective outcomes;
- builds on shared responsibility and decision-making among users and providers;
- ensures accountability, at all levels, for outcomes; and
- is cost-effective and sustainable in the long term.

In addition to meeting the requirements specified in the *Canada Health Act*, the Department also provides full and/or partial coverage for a number of other health care services, such as:

- home care and long-term care;
- mental health services;
- Extended Health Benefits for senior citizens, recipients of the Alberta Widows' Pension (and the eligible dependants of both);
- palliative care;
- immunization programs for children; and
- some allied health services such as optometry (for residents under 19 and over 65 years), chiropractic, podiatry, etc.

Regional Health Authorities and Provincial Health Authorities

In Alberta, 17 regional health authorities and two provincial health authorities deliver health services. The regional health authorities are responsible for hospitals, continuing care facilities, community health services and public health programs in the province. They deliver health services in the regions and work with communities to provide health services locally.

The two provincial health authorities (the Alberta Cancer Board and the Alberta Mental Health Board) provide health services on a province-wide basis.

Regional Health Authority Funding

Beginning with the 1997-1998 fiscal year, Alberta adopted a new method of funding regional health authorities to ensure that each region received its fair share of available health dollars. This funding method is referred to as "Population-Based Funding". Under this method, funds are allocated to each regional health authority according to the population in each region and their estimated relative health care expenditure requirements.

The population's health care expenditure requirements are measured by taking into account:

- the total population base of each region;
- the age and gender of the population base;
- the socio-economic composition of the population base; and

- services provided by regions to residents of other regions.

Province-wide Services Funding

Province-wide services funding is targeted to provide a range of high-cost, high-tech, life-sustaining services that are funded separately from the basic health services covered under population-based funding. Province-wide services planning, delivery and standards setting are collaborative efforts between the Department and the Calgary Health Region and Capital Health Authority. These services are only delivered in Edmonton and/or Calgary. Therefore availability of centrally funded services to all Alberta residents, regardless of where they live, is ensured.

Alberta Health Care Insurance Plan Statistics

In the 2000-2001 fiscal year there were 4,856[1] physicians and 2,910[1] allied health practitioners registered with the Alberta Health Care Insurance Plan. There were 3,007,582[1] residents registered with the Alberta Health Care Insurance Plan.

In 2000-2001, the Alberta Health Care Insurance Plan issued a total of $959,073,855[1] in fee-for-service payments to Alberta physicians and a total of $57,804,028[1] to Alberta allied health practitioners, (dental surgeons, dentists, chiropractors, optometrists, podiatrists), for basic health services.

Key Alberta activities in 2000-2001 were:

- proclamation of the *Health Care Protection Act* and Regulations on September 28, 2000;
- negotiations/amending agreement entered into with the Alberta Medical Association;
- continuation of the development of the Relative Value Guide (RVG);
- four additional Magnetic Resonance Imaging (MRIs) machines added to the health system: two in Calgary and two in Edmonton;
- a pilot project to cover special high-cost dental treatment for Albertans with congenital conditions, cancer or other trauma who require certain orthodontic services that are needed before insured oral and maxillofacial surgical services can be performed was introduced in Alberta;
- meningitis immunization programs were launched in "high-risk" areas of the province;
- eight postgraduate training positions were opened to international medical graduates at the University of Alberta and University of Calgary;
- the Department approved a new drug treatment (Ocular Photodynamic Therapy) for macular degeneration; and
- effective April 1, 2000, commenced paying for accommodation and subsistence costs (for those persons approved by the Out of Country Health Services Committee under Section 26.1 of the Alberta Health Care Insurance Regulation), to travel outside of Canada to receive insured services or insured hospital services on an out-patient basis.

Some of the major challenges facing the Department are:

- drug costs;
- technology and the change in demographics;
- public expectations and demands for services; and
- sustainability of health care in Alberta.

The Premier's Advisory Council on Health has been established to identify strategies to maintain an effective, high-quality health care system for Albertans.

Additional information on Alberta Health and Wellness can be obtained on our website at www.health.gov.ab.ca

[1] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan is operated on a non-profit basis and is administered by the Minister of Health and Wellness.

The Alberta Health Care Insurance Plan is governed by the *Alberta Health Care Insurance Act* and Regulations. The *Alberta Health Care Insurance Act* was proclaimed in 1969. It provides benefits for basic health services to all Alberta residents, as defined in the *Alberta Health Care Insurance Act*, and extended health services to residents 65 years of age or older, or those who are receiving the Alberta Widows' Pension and their eligible dependants.

- Part 1, Section 3 of the *Alberta Health Care Insurance Act* authorizes the operation of the Alberta Health Care Insurance Plan.
- Section 4 describes "coverage under the Alberta Health Care Insurance Plan".
- Section 5 describes payment of benefits and emergency services. Section 5 also prohibits extra-billing and identifies "other prohibited fees".

There were no legislative amendments that changed the name or public authority of the Alberta Health Care Insurance Plan in 2000-2001.

The role and mandate of the Department is:

- to preserve, protect and improve the health of Albertans and the quality of the health system;
- to develop health policy and standards and identify resources required to sustain the health system and meet Albertans' health needs on an ongoing basis; and
- to ensure that health services are appropriate, well managed and accessible to all Albertans.

1.2 Reporting Relationship

The Alberta Health Care Insurance Plan is administered through the Program Services Division of the Department. The Assistant Deputy Minister of the Program Services Division reports to the Deputy Minister of the Department, who in turn reports to the Minister of Health and Wellness. The Minister is accountable to the Legislative Assembly and the Government of Alberta. In turn, the Government of Alberta is accountable to all Albertans.

The Department issues an Annual Report that contains the Ministry's Accountability Statement, Management Responsibility for Reporting and the consolidated financial statements of the Ministry of Health and Wellness. In addition, the Annual Report provides information about the actions, key achievements and results for all key performance measures included in the 2000-2001 business plan for each of the Department's four goals that support the two core businesses of the Department.

The two core businesses of the Department are:

- to lead and support a system for the delivery of quality health services, and
- to encourage and support healthy living.

The Department's Annual Report for the year ended March 31, 2001 was prepared under the direction of the Minister of Alberta Health and Wellness in accordance with the Departments *Government Accountability Act* and the Government's accounting policies.

- Section I of the Annual Report contains the audited consolidated financial statements of the Department and a comparison of actual performance results to desired results set out in the Ministry's Business Plan.
- Section II provides financial statements of the regional health authorities and provincial boards, which are accountable to the Minister of Alberta Health and Wellness.

The Department also issues an annual statistical supplement report on data related to the Alberta Health Care Insurance Plan, primarily the number of people registered and the fee-for-service payments made to Alberta physicians and allied practitioners, i.e., oral and dental surgeons, chiropractors, optometrists

and podiatrists. Statistics regarding the Extended Health Benefits (EHB) Program and the Alberta Blue Cross Non-Group coverage offered through the Alberta Health Care Insurance Plan are also provided in this statistical supplement report.

1.3 Audit of Accounts

The financial statements of the Alberta Health Care Insurance Plan are now included as part of Alberta Health and Wellness audited financial statements. The Ministry's financial statements are audited by the Auditor General of Alberta.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospitals Act* (Revised Statutes of Alberta 1980, Chapter H-11 with amendments in force as of December 1, 1997), the Hospitalization Benefits Regulation (AR244/90), the *Health Care Protection Act*, proclaimed September 28, 2000, and Health Care Protection Regulation, are the legislative authorities that provide for insured services provided in hospitals or designated surgical facilities in Alberta.

There were no amendments made to the *Hospitals Act* or the Hospitalization Benefits Regulation in 2000-2001.

The Minister of Alberta Health and Wellness administers the *Hospitals Act*. Regional health authorities are accountable for ensuring the overall management and delivery of all hospital services within their regions. In accordance with the *Hospitals Act* and Regulations, they are required to provide specifically identified "Insured Hospital Services". Services provided beyond "Insured Hospital Services" are at the discretion of the individual regional health authority.

The *Hospitals Act* defines insured services as "the hospital services the operating costs of which will be provided for under this Part" and goes on to define Standard Ward Hospitalization and where insured services shall be furnished. These services are set out in the Hospitalization Benefits Regulation (AR244/90).

The Hospitalization Benefits Regulation describes "insured services" as follows:

"(a) to in-patients:

(i) a semi-private or private room, where a patient's medical condition makes it necessary;

(ii) private nursing care for a patient when ordered by the attending physician and approved in accordance with the hospital's by-laws;

(iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital;

(iv) pacemakers, steel plates, pins, joint prostheses, valve implants and any other goods approved by the Minister;

(v) transportation in Alberta, whether by ambulance or other commercial vehicle to transport a patient in the circumstances described in section 6, [i.e. transfer from one hospital to another].

(vi) goods and services included in an approved hospital program or a specific program, but not included in subclauses (i) to (v).

(vii) enhanced goods or services provided under section 5.2(2); [must be a medical necessity as determined by an attending physician]

(b) to out-patients: any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility."

Effective April 12, 2000, monofocal rigid or foldable lens implants were provided to patients, without charge, as part of the insured hospital service, when provided in conjunction with an insured physician service.

Effective September 28, 2000, both plaster and fibreglass casts were provided to patients, without charge, as part of the insured hospital service, when provided in conjunction with an insured physician service.

In June 2000 coverage was provided for ocular photodynamic therapy using Visudyne to treat wet macular degeneration.

Table 1 identifies the number and types of facilities operating in Alberta in fiscal 2000-2001.[2]

Table 1: Health Care Facilities by Type*	
Acute Care Facilities (facilities that offer health services that are provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation)	102
Chronic Care Facilities (facilities that offer health services to in-patients who need assistance on a continuing basis due to chronic impairment lasting at least several months)	105
Rehabilitative Facilities (facilities that offer health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury)	1
Other (Community Care Facilities)	3
Total	**211**

*excludes psychiatric hospitals and nursing homes

Non-hospital surgical facilities (facilities that offer health care services involving medical operative procedures that do not require an overnight stay in the facility for post-operative recovery or observation – including private cataract/abortion/dental/optometry clinics) and non-hospital diagnostic facilities (facilities that offer health care services for procedures that do not require an overnight stay and that detect and/or determine various diseases or health conditions) also operate in the province. These facilities operate under agreements and/or contracts with the regional health authorities. Alberta Health and Wellness collects data only on the insured fee-for-service procedures performed in these facilities and does not collect data on insured hospital services provided within the facilities. According to the College of Physicians and Surgeons of Alberta, there are currently 52 non-hospital day surgical facilities accredited under the College by-laws. These provide both insured and uninsured day surgery.

Currently there are 36 contracts for insured surgical services with 33 facility operators. The Minister approved 34 of the 36 contracts after the *Health Care Protection Act* was proclaimed. Two existing contracts, which expired after the Act's proclamation, were deemed to be approved. Any amendments or renewal of these two contracts requires ministerial approval. The types of insured surgical services provided by these 36 facilities are ophthalmology; dermatology; ear, nose and throat treatment; oral surgery; orthopaedics; pregnancy termination and plastic surgery.

Copies of the 35 contracts with the Capital Health Authority and the Calgary Health Region are posted on their websites. The contract with the Headwaters Health Region is not available on its website; however, a hard copy is available by calling its corporate office at (403) 601-8330. Information about the contracts approved by the Minister is available on the Alberta Health and Wellness website at www.health.gov.ab.ca.

On September 28, 2000, the Government proclaimed the *Health Care Protection Act* and enacted the Alberta Health Care Protection Regulation under which accredited surgical facilities must operate.

The *Health Care Protection Act* sets out the strongest rules in the country for protecting the publicly funded health system by filling gaps in current legislation, providing protection for the publicly funded and administered health care system, preventing a two-tier system, and providing health authorities with a further option to improve access to services.

Under this Act:

- private hospitals are prohibited from operating;
- surgical facilities are allowed to provide insured surgeries only when they have contracts with a health authority and only when the health authority can demonstrate that there is a net benefit to the public system;

[2] The Alberta section of the 1999-2000 Canada Health Act Annual Report did not reflect Chronic Care or Rehabilitative Care Facilities. This year, based on the definitions provided for the various facilities, as provided by Health Canada, and agreed to by the Provinces and Territories, we have changed this portion of the Narrative to reflect the same facility categories as listed in Annex A of this report (see Provincial and Territorial Health Care Insurance Plan Statistics).

- facility fees for insured surgical services are illegal;
- it is illegal to jump the queue for insured surgeries by paying or receiving money or by purchasing an uninsured surgical service or an enhanced product or service;
- charges for extra medical products and services that are not medically necessary have been limited; and
- patients and the health system are protected from unethical behaviour or conflict-of-interest situations.

Under the *Health Care Protection Act*, non-hospital surgical facilities must:

1. be accredited by the College of Physicians and Surgeons to provide the insured surgical services;
2. have an agreement for the provision of these insured surgical services with a health authority that has been approved by the Minister; and
3. be designated by the Minister to provide these insured surgical services.

The Act also specifies the conditions that must be satisfied for the Minister to approve an agreement between a health authority and a non-hospital surgical facility. The provision of insured surgical services, as contemplated under the Agreement, is assessed in relation to factors such as consistency with the *Canada Health Act*, current and ongoing need in the geographical area for the service, potential for adverse impact on the publicly funded and publicly administered health system in Alberta, expected public benefit such as better access, improved quality, flexibility, improved efficiency, and improved cost effectiveness.

Once the Minister approves the proposed agreement between a health authority and non-hospital surgical facility and is satisfied that the facility is accredited to provide insured surgical services, the Minister is required to designate the facility. Designation includes describing the insured surgical services that the surgical facility is authorized to provide, any terms and conditions that the designation is subject to, and the Minister's publishing or otherwise making public his or her reasons for designating a facility or amending a designation.

The current process for establishing an approved hospital status (acute care hospitals and auxiliary hospitals) involves departmental review and ministerial approval. For a new hospital this process includes a regional needs assessment; a program and service plan; a hospital functional programming study; identification of functional centres; facility registration and inclusion in the Ministerial Order - "Schedule of Approved Hospitals". Updates to approved hospital status that include amendment to or consolidation of the Ministerial Order – "Schedule of Approved Hospitals" requires certification by the health region that all relevant approved hospital data and current common names are accurate and that the approved hospitals are operating in accordance with applicable federal, provincial and departmental legislation and standards.

Publicly owned nursing homes are operated by regional health authorities. Regional health authorities negotiate and approve contracts for the operation of private or voluntary owned and operated nursing homes. Under the *Nursing Homes Act*, Part II, Section 6, regional health authorities are responsible for providing the Minister with copies of all nursing home contracts.

Continuing Care Facilities

In Alberta, long-term care facilities are classified as either nursing homes or auxiliary hospitals under current legislation. Collectively these are now referred to as continuing care facilities.

Auxiliary Hospital
Under Section 1(1)(c) of the *Hospitals Act*, "auxiliary hospital" means a hospital for the treatment of long term or chronic illnesses, diseases or infirmities. Auxiliary hospitals are owned by regional health authorities or voluntary, non-profit societies and are operated under the *Hospitals Act* and its Regulations.

Nursing Home
Under Section 1(m) of the *Nursing Homes Act*, "nursing home" means a facility for the provision of nursing home care.

Nursing homes are owned by regional health authorities, voluntary societies or private

corporations and are operated under the *Nursing Homes Act* and its regulations. Where a nursing home or auxiliary hospital is owned by a voluntary, non-profit society or private corporation it is operated under a service contract or agreement with the regional health authority.

Continuing care facility operators are responsible for providing all services required under the *Nursing Homes Act* and Regulations and the *Hospitals Act* and Regulations.

These include:

- services provided by auxiliary hospitals and nursing homes such as professional and ancillary nursing care, pharmacy, nutrition, physical therapy services and accommodation services (e.g. laundry, housekeeping, maintenance and administration);
- trust account services;
- supplies for recreation programs;
- medications or drugs and related preparations as prescribed by the attending physician, including oxygen;
- all dressing and wound-care supplies;
- incontinence products and bladder care equipment;
- transportation, including ambulance transport, for prescribed services;
- nutritional supplements as prescribed by the attending physician;
- basic room furniture; and
- special care items such as handrails, sheepskin pads, elbow and ankle protectors, pressure mattresses, side-rail pads, etc.

Section 25(1)(h) of the *Health Care Protection Act* gives the Lieutenant Governor in Council the authority to prescribe whether a particular medical good or service is or is not a standard or an enhanced good or service. The Health Care Protection Regulation sets out major surgical services, minor surgical procedures and standard and enhanced medical goods and services. Adding or removing an item from the Health Care Protection Regulation requires an amendment to the Regulation and the requirements of the Government's regulatory review process must be followed. Routine decisions regarding equipment and supplies used in procedures are the purview of the health authorities and practitioners and are excluded from this process.

The Department is developing a process to define standard and enhanced medical goods and services that will be used on an exception basis to examine medical goods and services that cannot be dealt with by a single health authority, or where an inconsistency in benefits has been identified across regions.

2.2 Insured Physician Services

The Medical Benefits Regulation governs the services for which benefits are payable, as well as the requirements for submission of fee-for-service claims to the Alberta Health Care Insurance Plan. This regulation sets the rates for benefits as those "set out in the Schedule of Medical Benefits prepared and published by the Department and approved by the Minister".

There were no amendments to the Legislation or Regulations in 2000-2001 with regard to insured physician services.

The *Alberta Health Care Insurance Act* defines "physician" as:

- "With reference to medical services provided in Alberta, a person registered as a medical practitioner or as an osteopathic practitioner under the *Medical Profession Act*, and
- With reference to medical services provided in a place outside Alberta, a person lawfully entitled to practise medicine or osteopathy in that place."

The *Alberta Health Care Insurance Act* defines "practitioner" as:

- "A chiropractor, dental mechanic, dental surgeon, optician, optometrist, physician or podiatrist or other person who provides a basic health service or an extended health service."

The *Medical Profession Act* defines "registered practitioner" as:

- "A person registered in the Alberta Medical Register or who is temporarily registered under Section 28."

Requirements for Physicians and Practitioners

Only those who meet the above requirements are allowed to provide insured physician services under the Alberta Health Care Insurance Plan.

Medical practitioners' offices must be registered by the Department. Practitioners must see patients at the location, book appointments from the location and maintain patient files at the location in order to be registered by the Department.

Prior to being registered with the Department, a practitioner must complete the appropriate registration forms and include a copy of his/her licence (issued by the appropriate governing body/association – e.g. the College of Physicians and Surgeons of Alberta, the Alberta Dental Association, etc.).

The number of practitioners registered with the Alberta Health Care Insurance Plan as of March 31, 2001, is as follows[3]:

Physicians	4,856
Oral Surgeons/Dentists	1,484
Chiropractors	689
Optometrists	243
Podiatrists	44
Denturists	191
Opticians	259
TOTAL	7,766

Physicians Opting out of the Alberta Health Care Insurance Plan

In accordance with section 5.11(1) of the *Alberta Health Care Insurance Act*, every physician is deemed to have opted into the Alberta Health Care Insurance Plan.

A physician may practise and bill patients for services outside of the Alberta Health Care Insurance Plan. A physician who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions, at least 180 days prior to the effective date of the opting out.

These conditions include:

- notifying the Minister, in writing, of his/her intention to opt out, indicating the effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practises; and
- posting a notice of the proposed opting out in a part of the physician's office to which patients have access.

As of March 31, 2001 there was one medical practitioner in the Province who had opted out of the Alberta Health Care Insurance Plan.

Schedule of Medical Benefits

The Medical Benefits Regulation (AR 173/93) describes the services for which benefits are payable. These services are set out in the Schedule of Medical Benefits prepared and published by the Department and approved by the Minister. Specifically, these are:

- general medical services;
- general medical and surgical procedures;
- anaesthesia;
- laboratory medicine and pathology;
- obstetrics;
- gynaecology;
- cardio-thoracic and vascular surgery;
- general surgery;
- orthopaedic surgery;
- neurosurgery;
- urologic surgery;
- otolaryngology;
- ophthalmology;
- reconstructive plastic surgery;
- medicine;
- psychiatry;

[3] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

- paediatrics;
- dermatology;
- physical medicine and rehabilitation;
- emergency medicine;
- diagnostic radiology;
- therapeutic radiology; and
- neurology.

Alberta also covers unlisted services that are deemed medically required and are not experimental or applied research.

Insured physician services and any subsequent additions, deletions or amendments to the Schedule of Medical Benefits are discussed between the Department and the Alberta Medical Association through a subcommittee composed of Alberta Health and Wellness and Alberta Medical Association members. Changes to the Schedule of Medical Benefits require ministerial approval.

During the period April 1, 2000 to March 31, 2001, the following services were added to the list of insured physician services covered by the Alberta Health Care Insurance Plan.

- rotation duty – off-hours benefits;
- pre-lung transplant, assessment;
- post-lung transplant, in-patient care;
- balloon dilation of lower gastrointestinal (ileum or colonic) stricture in association with colonoscopy;
- balloon dilation of lower gastrointestinal stricture (ileum or colonic) stricture in association with sigmoidoscopy;
- balloon dilation of upper gastrointestinal stricture (stomach, duodenum or jejunum);
- removal of double "J" stent;
- management of shoulder dystocia;
- selective fetal reduction;
- reconstruction of collateral ligament and/or the volar plate of the MP or IP joint;
- intravaginal trigger point injection(s);
- effective June 1, 2000 consultation benefits may be paid to physicians when a midwife refers a patient to them for a consultation;
- hyperbaric oxygen therapy detention time – over 15 minutes;
- debridement of mastoid cavities and/or repair of small perforation – under microscopy;
- application of fibreglass cast, lower limb;
- application of fibreglass cast, upper limb, excluding finger;
- ilioplasty, bone graft to iliac crest following harvesting of bone for neurospinal surgery;
- prolonged psychiatry consultations per additional 15 minutes, when the consultation exceeds 60 minutes;
- assessment of an unrelated condition in association with a Workers' Compensation service;
- second and subsequent physician attendance at a formal, scheduled, professional interview/case conference on behalf of a specific patient 18 years of age and under, per 15 minutes;
- peripheral embolectomy or endarterectomy (note: may only be claimed in association with other vascular surgery through the same arteriotomy);
- endoscopic ultrasound of esophagael or gastric lesions; and
- endoscopic ultrasound of rectal lesions.

2.3 Insured Surgical-Dental Services

Under the Alberta Health Care Insurance Plan, the Province insures a number of medically necessary oral surgical procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits. A dentist or dental surgeon may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan only when performed by an Oral and Maxillofacial Surgeon.

Dentists (or dental surgeons) must be registered as members of the Alberta Dental Association or must be entitled to practise dental surgery in any place outside Alberta. Oral and Maxillofacial Surgeons must be dental specialists in oral and maxillofacial surgery,

registered as members of the Alberta Dental Association, or be lawfully entitled to practise oral and maxillofacial surgery in any place outside Alberta.

As of March 31, 2001, there were 1484[4] oral surgeons and dentists registered with the Alberta Health Care Insurance Plan, providing services under both the Extended Health Benefits Program for seniors and the insured surgical dental services program. However, during the 2000-2001 fiscal year, only 232[4] dentists and oral surgeons billed the Alberta Health Care Insurance Plan for insured oral surgery procedures.

Provisions of opting in and out of the Alberta Health Care Insurance Plan by dentists are set out in section 5.1(1) of the *Alberta Health Care Insurance Act*. Subject to this section, every dentist is deemed to have opted into the Alberta Health Care Insurance Plan.

A dentist may practise and bill patients for services outside the Alberta Health Care Insurance Plan. A dentist who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions, at least 180 days prior to the effective date of the opting out. These conditions include:

- notifying the Minister, in writing, of his/her intention to "opt out", indicating the effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the dentist practises; and
- posting a notice of the proposed opting out in a part of the dentist's office to which patients have access.

As of March 31, 2001, no dentists or oral surgeons had opted out of the Alberta Health Care Insurance Plan.

The following procedures are insured under the Alberta Health Care Insurance Plan and are listed in the Oral and Facial Surgery Benefits Regulation: (note: decisions as to (a) whether the procedure is medically necessary, and (b) where it should be performed; are left to the surgeon and depend on the medical needs of the patient):

- diagnostic interview and evaluation or consultation;
- arthroscopy temporo-mandibular joint;
- injection or infusion of other therapeutic or prophylactic substance;
- cranioplasty;
- operations on cranial peripheral nerves;
- submucous resection of nasal septum;
- reduction of nasal fracture; intransal antrotomy;
- repair and plastic operation of nasal sinus;
- excision of dental lesion of jaw; other orthodontic operation;
- repair and plastic operations on tongue;
- other operations on tongue;
- incision of salivary gland or duct;
- excision of lesion of salivary gland;
- other operations on salivary gland or duct;
- drainage of face or floor of mouth;
- incision of palate;
- excision of lesion or tissue of palate; plastic repair of mouth (internal);
- palatoplasty;
- invasive diagnostic procedures on oral cavity;
- other operations on mouth and face;
- plastic operation on pharynx;
- control of hemorrhage, not otherwise specified;
- reduction of facial fractures;
- incision of facial bone without division;
- temporomandibular arthroplasty;
- other facial bone repair and osteoplasty;

[4] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001*.

- invasive diagnostic procedures on facial bones;
- other operations on facial bones and joints;
- sequestrectomy;
- synovectomy;
- repair and plastic operations on joint structures;
- incision of muscle, tendon, fiscia and bursa;
- relaxation of scar or contracture of skin;
- flap or pedicle graft; and
- oral and burn appliances.

The Claims Branch in the Program Services Division of the Department manages any addition of new surgical-dental items to the list of insured services. Changes to the schedule require ministerial approval. All changes (both addition and deletion of items) are done through extensive consultation with the Department, the Alberta Dental Association and the Oral Maxillofacial Surgery section of the Alberta Dental Association, and are supported by impact assessment studies. Depending on the changes, the regional health authorities may also be consulted.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 4(2) of the Hospitalization Benefits Regulation provides a listing of uninsured hospital services. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Services required for the use of third parties, services covered under another provincial/territorial/federal statute, services that have been deemed unnecessary for the patient (i.e., enhanced goods and services), laboratory and x-ray services, drugs, biologicals and related preparations (in some circumstances), and services provided by a facility outside of Canada without the prior approval of the Minister, are the types of uninsured services listed in the Hospitalization Benefits Regulations.

The *Health Care Protection Act* (Section 5) and Regulations specify the conditions that apply when patients are charged for enhanced medical goods and services related to the provision of an insured surgical service. These provisions of the legislation apply to both public hospitals and non-hospital surgical facilities. The legislation limits charges to those enhanced medical goods or services that are listed in Schedule 2 of the Regulation. Currently, there is only one enhanced medical good listed: multi-focal intraocular lens implants. It also specifies the method for determining the amount that may be charged for an enhanced medical good or service. As well, the legislation includes disclosure provisions that apply when an enhanced medical good or service is offered to a patient, i.e., patients must be advised that the standard medical good or service meets generally accepted medical practise and is available at no charge. These are only some of the key provisions relating to the sale of goods and services.

Section 21 of the Alberta Health Care Insurance Regulations, sets out the services that are not basic health services or extended health services and therefore are not considered insured services. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Briefly, some of the services that are not considered insured services under this regulation are services provided for third parties, (insurance companies, medico-legal services, etc.); advice by telephone or other means of telecommunication (including toll charges for same); transportation costs (includes costs of both patients and practitioners as well as ambulance costs, unless otherwise directed by the Minister); services covered under another provincial/territorial/federal statute; group immunizations; services provided by a practitioner to his children, siblings, parents and/or spouse, except where the Minister rules otherwise, etc.

The Schedule of Oral and Maxillofacial Surgery Benefits details the services that are not insured benefits under that Schedule. The Schedule is detailed in the section entitled Additional Materials Submitted to Health Canada that appears at the end of this narrative. Some of these items are: services that are cosmetic in nature; drugs/medication; advice by telephone; ambulance services; services that are not medically required; travel time; and services provided by a practitioner to his or her children,

siblings, parents and/or spouse, except where the Minister rules otherwise; etc.

Regional Health Authority Responsibilities

Section 5 (Responsibilities of Authority) of the *Regional Health Authorities Act* states "Subject to this Act and the Regulations, a Regional Health Authority: shall (i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury, (ii) assess, on an ongoing basis, the health needs of the health region, (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly, (iv) ensure that reasonable access to quality health services is provided in and through the health region, and (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region". Regional health authorities are responsible for ensuring that decisions related to access to insured hospital and other community health services are based on need.

Billing Outside the Alberta Health Care Insurance Plan

In accordance with Section 31.1(1) of the Alberta Health Care Insurance Regulations, no person may charge a fee (a) the payment of which is a condition of receiving an insured service provided by a physician who is enrolled in the Alberta Health Care Insurance Plan or a dental surgeon who is opted into the Alberta Health Care Insurance Plan, and (b) that is in addition to the benefit payable by the Minister for the insured service.

In accordance with the *Canada Health Act*, the Alberta Health Care Insurance Plan covers the medically required services physicians provide to patients. When a service is not medically required, physicians may bill a patient for that service. The Department does not regulate physicians' billings for uninsured services. The College of Physicians and Surgeons of Alberta has developed and enforces a policy on this issue entitled *Charging for Uninsured Services*, and the Alberta Medical Association provides the *Guide to Direct Billing for Uninsured Services* to physicians.

The Alberta Health and Wellness/Alberta Medical Association agreement defines de-insurance as "...in respect of an insured service, the decision of the Minister that such insured service is no longer an insured service and no longer payable under the Plan." According to this agreement, Alberta Health and Wellness must notify the Alberta Medical Association of any proposal to de-insure, and the proposal must be discussed by the Finance Committee, the joint Alberta Health and Wellness/Alberta Medical Association body that manages the Agreement. If the Alberta Medical Association does not agree to de-insure the service, Alberta Health and Wellness must wait three months from the notification date to remove the service from the Schedule of Medical Benefits.

Before items are de-insured (deleted) from the Schedule of Oral and Maxillofacial Surgery Benefits, Alberta Health and Wellness consults with the Alberta Dental Association.

In reviewing whether new medical products, services or devices should be publicly funded, the Department's process is to first review the scientific literature and seek expert advice as to the safety and effectiveness of the product, and next to issue the policy, funding, training and other implications of providing public coverage. Issues requiring immediate attention are addressed on an issue management basis with the most appropriate branch taking the lead.

3.0 Universality

3.1 Eligibility

Sections 3(1) and 4(3) of the *Alberta Health Care Insurance Act;* Sections 4(1), 4(2), 4.1 and 4.2 of the Alberta Health Care Insurance Regulations, Section 18.2 of the *Health Insurance Premiums Act*, and Section 21 of the Health Insurance Premiums Regulation define eligibility for the Alberta Health Care Insurance Plan.

All Alberta residents are eligible to receive services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada who makes his or her home and is ordinarily present in Alberta and any other

person deemed by the Regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

Persons from outside Canada who move to Alberta to establish permanent residence are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. All new landed immigrants must provide a copy of their Record of Landing. Temporary residents arriving from outside Canada, who may be deemed residents, include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits.

In each of these cases, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that in Alberta to be eligible.

Refugee claimants who entered Canada before January 1, 1989, and who intended to reside in Alberta for 12 months were also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989 are not eligible for coverage until they are deemed to be Convention Refugees.

Persons moving permanently to Alberta from another country are eligible for coverage on their date of arrival, provided all Canada entry documents are in order and they register within three months of arrival. Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

There were no amendments made to this legislation, or the Regulations, in 2000-2001.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan are:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
- persons serving a term in a federal penitentiary.

However, their family members are eligible for coverage.

Alberta residents who cease to be members of the Canadian Forces, the RCMP, or inmates federal penitentiaries and are released in Alberta are eligible for coverage on the day of their release.

3.2 Registration Requirements

All new Alberta residents, except those specifically exempt, are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan by completing an application. New residents to Alberta should apply for coverage within three months of arrival. If the application is not received within the required time, the effective date is determined at the time of registration. Following registration, the account holder and dependants, if any, are each given a personal health number and card, which is used to obtain health services.

Family members are registered on the same account for billing purposes and to ensure that benefits (e.g., extended health benefits, non-group Blue Cross) can be provided to all members of the family unit.

In most cases, dependants are defined as a husband and wife and children under 21 years of age who are single and wholly dependent on the parent(s). Dependants can also be:

- adopted children, foster children and wards for whom the resident is entitled to claim income tax deductions;
- single children over 21 who are wholly dependant because of physical or mental disabilities;
- single children under 25 who are full-time students at an accredited educational institution; and
- separated or common-law spouses, who may also choose to pay premiums independently.

As of March 31, 2001, the estimated number of residents registered with the Alberta Health Care Insurance Plan was 3,007,582[5].

Residents who object to the Alberta Health Care Insurance Plan may opt out of the Alberta Health Care Insurance Plan. Residents can opt-out at the beginning of each benefit period. A benefit period begins July 1 of one year and ends June 30 of the following year. A Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year and premiums must be fully paid to June 30 of the current year. New account holders can opt out at the time of registration or reinstatement. The opt out period begins the day coverage would have become effective. To remain opted out, a Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year.

233 individuals had opted out of the Alberta Health care Insurance Plan for the benefit period July 1, 2000 to June 30, 2001.

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits. In each of these cases, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that time in Alberta to be eligible. Refugee claimants who entered Canada before January 1, 1989 and who intend to reside in Alberta for 12 months, are also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989 are not eligible for coverage until they are deemed to be Convention Refugees.

The following figures show the estimated number of individuals residing in Alberta who were covered under the above conditions on March 31, 2001:

Minister's Permit	158
Student Authorization	5,038
Visitor's Record	3,058
Employment Authorization	5,110

3.4 Premiums

All residents of Alberta, except dependants and individuals excluded from registration, are required to pay premiums. Individuals enrolled in special groups, such as Alberta Widows' Pension and Support for Independence, are exempt from paying premiums. The current monthly premium rates are $34 for single coverage and $68 for family coverage (two or more people). There are two programs available to assist low-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program. Seniors are required to pay premiums at the same rates as non-seniors. Seniors' eligibility for premium assistance is determined through the Alberta Seniors Benefit Program.

Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to do so.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and Section 1(2) of the Alberta Health Care Insurance Regulations define portability of health insurance during temporary absences in Canada.

[5] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

Residents leaving Alberta for another part of Canada for 12 months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than 12 months, coverage may be cancelled or residents have the option of applying for extensions. These extensions are:

- extended visits or vacations, to a maximum of 24 consecutive months from date of departure. Extensions must be requested in person, by phone or in writing;
- employment or business engagements, to a maximum of 48 consecutive months from date of departure. A letter from the employer confirming the length of the business contract is required;
- a full-time student at an accredited educational institute are provided coverage until their educational training is completed. After the first year, verification of full-time student status must be submitted yearly to maintain coverage;
- sabbatical leave or educational leave from employment for advanced training, to a maximum of 24 consecutive months from date of departure. A letter from the employer confirming their training and length of absence is required;
- missionary work for an approved registered organization, to a maximum of 48 consecutive months from the date of departure. A letter from the religious organization confirming date of departure, destination and length of absence is required. Missionaries may return to Alberta on furlough (leave of absence or vacation) from their duties. The period of time they are in Alberta is counted as part of their temporary absence and does not indicate they have re-established permanent residence.

Effective November 15, 2000, the Alberta Health Care Insurance Regulation was amended to: define temporary absences as those that will not exceed six months outside Canada or 12 months within Canada; eliminate the provision that made coverage mandatory for the first 12 months, even if the absence is for longer than 12 months; and remove the reasons for absences and the timelines so they can be established in policy. This will better accommodate those who want to maintain coverage for longer periods of temporary absence as well as those who want to cancel coverage during an extended absence.

Hospital Reciprocal Agreement

Alberta participates in the Hospital Reciprocal Agreement with the provinces and territories, which allows for the processing of hospital costs provided to Albertans and non-Albertans by the host province. Claims are paid at the standard ward rate for in-province insured services approved by each provincial/territorial jurisdiction and at the out-patient rates for insured services approved by the Co-ordinating Committee on Reciprocal Billing. Exchange of claims data between each jurisdiction takes place on a monthly basis.

Medical Reciprocal Agreement

Alberta also participates in the Medical Reciprocal Billing Agreement with the provinces and territories (except Quebec). The Agreement allows for the processing of medical costs provided to Albertans and non-Albertans by the host province. Claims are paid in accordance with the rates, rules and regulations of the host provinces' physician's fee schedule for insured medical services. Exchange of claims data between the provincial/territorial jurisdictions takes place on a monthly basis.

Services excluded from this billing process, such as abortions, must be billed directly by the physician to the patient's home province/ territory for payment consideration.

The Capital Health Authority has also entered into an agreement with the Northwest Territories that allows for Northwest Territories patients to be treated within the region's hospitals and be paid at an agreed in-patient rate. The billing process for these claims is similar to the in-patient hospital reciprocal billing arrangement between the provinces and territories. Services that are excluded from reciprocal billing are also excluded from this bilateral agreement with the Northwest Territories.

Payment for insured hospital and medical services provided to eligible Albertans elsewhere in Canada is at the rate approved by the hospital insurance plan of the province or territory in which the goods or services are

provided, unless the Minister has entered into an agreement with the government of a province or territory to apportion the costs in a different manner.

Payments for insured medical services provided to eligible Albertans elsewhere in Canada are at the host provincial or territorial rates, including Quebec.

In 2000-2001, the total amount paid for in-patient and out-patient insured hospital services provided out-of-province (within Canada) was $19,602,875[6].

4.3 Coverage During Temporary Absences Outside Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and Section 1(2) of the Alberta Health Care Insurance Regulation define portability of health insurance during temporary absences outside Canada.

Alberta residents leaving Canada for six months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than six months, coverage can be cancelled or residents have the option of applying for extensions. These extensions are the same as for those temporarily absent within Canada (please see details in section 4.2 for a description of the extensions).

For a description of amendments made in 2000-2001 to the Legislation or Regulations with regard to out-of-Canada portability, please refer to details in section 4.2, paragraph 3. Effective November 15, 2000, amendments were made to the Alberta Health Care Insurance Regulation that affected temporary absences both within and outside of Canada.

Hospital benefits are payable only when services are provided in acute care facilities that provide standard services such as intensive care units or emergency ward, or auxiliary hospitals that provide standard acute care services to long-term or chronically ill patients. If services are not insured in the Province, they are not insured when provided outside the country. The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day, (not including day of discharge). The maximum hospital out-patient per visit rate is $50 (Canadian). Some specialists' out-patient services, such as CAT scans, are paid at higher rates.

Benefits for out-of-country practitioner services are payable according to the fee charged or the Alberta rate, whichever is the lesser.

Full coverage for treatment costs outside Canada may be provided under the following two programs:

1. the Out-of-Country Health Services (OOCHS) Program, which may apply where the required service is not available in Canada, and
2. the Emergency Financial Assistance Program, which may apply where the treatment expense could not have been guarded against.

4.4 Prior Approval Requirement

Prior approval is required for elective services received outside Alberta. Treatment of alcohol and substance abuse, eating disorders and similar addictive or behavioural disorders, whether received out-of-province or out-of-country, must be approved by the Minister prior to being received.

Requests for prior approval for "hospitalisation" and "medical" treatment outside Alberta but within Canada must be submitted to the Department, by the physician responsible for the ongoing care of the patient in Alberta, or by the physician of the applicable provincial jurisdiction. Applications for prior approval of out-of-country health services are submitted to the Out-of-Country Health Services Committee by the Alberta physician or by the patient.

[6] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Alberta is available to all residents on uniform terms and conditions, without barriers.

Those who are unable to pay premiums are not prevented from receiving insured health services. Registrations are not cancelled because of non-payment of accounts. Also, Alberta has two programs in place to assist low-income persons with payment of premiums.

These programs are:

- the Premium Subsidy Program, and
- the Waiver of Premiums Program.

Since 1986 "extra-billing" by physicians and "user charges" to patients for insured services have been prohibited.

Alberta's Good Faith policy allows practitioners to submit claims for services provided to patients who are unable to provide an Alberta health care number at the time of service. This can be done one time only per patient and the practitioner must first satisfy him/herself that the patient is an Alberta resident.

5.2 Access to Insured Hospital Services

Since 1994, the delivery of hospital services in Alberta has been the responsibility of the regional health authorities.

In February 2000, the Government of Alberta announced its 2000-2001 to 2001-2003 business plan outlining increases to the provincial health system.

Under this business plan, Alberta's health system expense increased by $482 million, an increase of 9.3 percent over the 1999-2000 base budget.

The increased spending improved access to publicly funded services and enabled regional health authorities to hire up to 2,400 more nurses and other front-line staff over the next three years. The budget also provided for an additional 90 physicians in 2000-2001 and an increase in the number of postgraduate residency positions in Alberta medical schools in the next two years. Funding increases also addressed waiting times for some procedures by increasing the number of life-saving surgeries performed, including major heart surgery, organ transplants, major cancer surgery and neurosurgeries. The new health care funding also increased home care services ($20 million), medical equipment purchases ($49 million), drugs and medical supplies ($29 million) and blood and blood products ($17 million).

The health authorities received an increase of $218 million or 7.7 percent in 2000-2001. Regional health authorities also received an increase of $47 million or 18.2 percent for province-wide services for key life-saving procedures primarily done in Edmonton and Calgary.

In May 2000 additional funding also provided:

- $54.4 million to reduce wait times for open-heart surgeries, joint replacements, MRIs and cancer treatments;
- $64 million to replace aging medical equipment. This brought the total for equipment to $112 million; and
- $20 million to expand long-term care and home care services.

The Ministry also provided $39 million to help pay for the costs of health authorities' negotiated salary settlements.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2000-2001 there were 4,856[7] physicians and 2,910[7] allied health practitioners registered with the AHCIP.

In 2000-2001, new funding initiatives for physician services included:

[7] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001*.

- an increase of $42.8 million (4.7 percent) for physician services;
- an increase of 2.2 million (16.7 percent) for rural initiatives to continue to enhance efforts to recruit and retain physicians for rural Alberta;
- a $6.6 million increase for post-graduate medical education training; and
- eight entry-level seats will be reserved for international medical graduates who are Alberta residents.

In 2000-2001, $260 million in funding was identified to add new long-term care beds and replace or renovate existing health facilities in the Province.

5.4 Physician Compensation

On April 20, 1998 Alberta Health and Wellness and the Alberta Medical Association signed a five-year master agreement governing the provision of physician services to Albertans for the period 1998 to 2004. All prior agreements were terminated and superseded by this new agreement. The Agreement covers three years of financial arrangements, 1998-1999 to 2001-2002, under which Alberta Health and Wellness provides an adjustable hard cap to pay for the fee-for-service billings by physicians and a number of physician benefit programs. The agreement was ratified by a majority of the Alberta Medical Association membership.

In January 2001, Alberta Health and Wellness and the Alberta Medical Association entered into an "amending agreement" to the April 20, 1998 Master Agreement. The terms of this amending agreement are in effect from April 1, 2001 to March 31, 2003, unless another effective date is expressed in any term of the Amending Agreement. Among other things, the Amending Agreement sets the Medical Service Budget for the 2001-2002 and 2002-2003 fiscal years, as well as the percentage to be used for estimating increases in population, when making adjustments to the adjustable hard-cap portion of the Medical Service Budget.

A Medical Services Delivery Innovation Fund to support the development of Alternate Payment Plans was also established by the Amending Agreement, as well as a Specialist On-Call Program to compensate specialist physicians for being on call and to enable to meet their responsibility of ensuring patients have the required access to specialist physicians. Under the terms of the Amending Agreement, Alberta Health and Wellness also committed to establishing an "On-Call Contingency Fund" to become effective April 1, 2002, for the purposes of funding changes that may arise from the review and evaluation of the effectiveness of Alberta physician on-call programs.

Section 4(1) of the *Alberta Health Care Insurance Act*, provides the authority for the Minister to pay benefits in respect of health services provided to residents of Alberta. There were no changes made to this legislation in 2000-2001.

Fee Structures

Most physicians in Alberta are paid on a fee-for-service basis for providing insured services. Some physicians find the fee-for-service funding and payment model to be restrictive. The Department and the Alberta Medical Association are working with health authorities, facilities and physicians to develop a number of Alternate Payment Plan (APP) projects as alternatives to fee-for-service. To date, the joint AMA/AHW APP Subcommittee has developed four new funding models. As with fee-for-service, APPs are funded from the Department's Medical Services Budget and **are not reflected in Annex A of this report** (see *Provincial and Territorial Health Care Insurance Plan Statistics*). In some circumstances, APP funding and fee-for-service may be blended in order to compensate physicians for services that are not part of the arrangement. APP projects may also be eligible for grant funding to help offset certain project-related expenses.

Four funding models have been developed by the APP Subcommittee.

- **Capitation** funding is generally associated with the delivery of primary medical care. Per capita funding is provided for the comprehensive care of each patient over a set period of time. The capitation rate is calculated by taking a number of factors into account, including patient age and gender and the pre-determined range of services to be offered by the practice.

- **Sessional** funding is based on units of time (e.g. hourly or daily) spent in the provision of defined insured medical services within an organized structure of program. Sessional funding arrangements must be part of a regional health authority program, and must adhere to a set service delivery model.
- **Contractual** funding is provided as a lump sum for the provision of a pre-determined volume of insured medical services over a specified period of time, such as a year (e.g. X dollars paid for 100 patient encounters or for performing 500 procedures of a certain type).
- **Block Funding** is a negotiated amount paid to a group of physicians to provide all insured services in a specific area of medical practice over a significant period of time (e.g. X dollars for the provision of all neurosurgical services in Northern Alberta over a three-year period).

5.5 Payments to Hospitals

The *Regional Health Authorities Act* sets out the requirements for the establishment and governance of Alberta regional health authorities.

In accordance with Section 8 of the *Regional Health Authorities Act*, the authority must submit a proposal for a health plan for the region to the Minister. This proposal must contain a statement as to how the authority proposes to carry out its responsibilities and measure its performance in the carrying out of those responsibilities, as well as information respecting health services to be provided and the anticipated cost of providing those services.

Regional health authorities are funded by the provincial government using a population-based funding formula. Additional funding is also provided to Edmonton and Calgary health authorities for the provision of specialised tertiary services (Province Wide Services) to all Albertans. In 2000-2001, $3.1 billion dollars in population-based block funding including Province Wide Services was provided to the regional health authorities.

Regional health authorities are accountable and report to the Minister of Health and Wellness. The Minister has the authority to request records, reports and returns from the regions, as well as an annual report on its activities. The annual reports are subsequently presented to the Legislative Assembly by the Minister and are included in the *Alberta Ministry of Health and Wellness Annual Report*.

There were no changes made to this legislation in 2000-2001.

6.0 Recognition given to Federal Transfers

The Alberta government publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2000-2001 Income Statement, the three-year business plan and on a schedule of revenues in the Department's financial statements. These transfers are also listed in the Ministry's Annual Report and Statistical Supplement. All of these documents are available to the public, either through the Queen's Printers, on our website at www.health.gov.ab.ca, or at some public libraries throughout the Province.

7.0 Extended Health Care Services

Alberta's Long Term Care Centres provide room and board and a range of care services, from personal care with nursing supervision to skilled medical and therapeutic services. In most instances, these auxiliary hospitals and nursing homes are referred to as Continuing Care Centres and meet the needs of residents with similar care requirements. Funding for Continuing Care Centres has been transferred to the 17 regional health authorities. Regional health authorities either operate the Continuing Care Centres or sign contracts with voluntary or private operators to deliver these services.

The Home Care Program is also delivered through the regional health authorities and provides a variety of professional health support services to assist individuals of all ages to return or remain at home. All Home Care

Programs provide assessment, case co-ordination and nursing and support services such as personal care and home support. Other services may include occupational, physical and respiratory therapy, speech-language pathology, social work and nutrition services.

Admission to the continuing care system, which includes Home Care, Continuing Care and Community Care Centres and Adult Day Programs, is based on a functional assessment of the individual's needs, using the Alberta Assessment and Placement Instrument. The Single Point of Entry process was developed to provide a single point of access to individuals seeking facility or community-based long-term care. Its purpose is to ensure that all possible community options are explored before facility-based care is considered. Home care staff conduct assessments, identify needs with clients and their families, and recommend health and support services that best suit these needs.

Alberta Aids to Daily Living

The Department also administers the Alberta Aids to Daily Living (AADL) Program. The purpose of AADL is to enhance the independence of clients living at home who have a chronic or terminal illness or disability, by assisting them with the provision of program-approved medical equipment and supplies. Clients are assessed for eligibility by authorizers working in community care, continuing care or acute care settings.

Alberta Mental Health Board, Mental Health Services

Mental health services delivered by the Alberta Mental Health Board (AMHB) include community clinics, two mental health hospitals, two care centres, 67 community mental health clinics and three satellite offices, as well as various non-profit community agencies. Services provided by the clinics include assessment and treatment of individuals and families and consultation to physicians, health facilities, health units, schools and community agencies. Two mental health hospitals provide assessment, treatment and rehabilitation for adults with mental illnesses, including mentally ill offenders, and for adults with brain injuries.

Two residential care centres provide long-term rehabilitation programs for people with severe mental illness. The AMHB also provides the governance function for four mental health provincial programs: Forensic Psychiatry, Geriatric Psychiatry, Adult Tertiary Care and Brain Injury.

Other mental health services provided by regional health authorities include specialized psychiatric services located in 17 hospitals throughout the Province. Family physicians, Home Care Programs and Continuing Care Centres also provide services to people with mental illness.

Alberta Cancer Board

In 2000-2001, the Department provided $123.8 million to the Alberta Cancer Board to support its operating and various research programs.

Additional Materials Submitted to Health Canada

Lists of uninsured hospital, physician and surgical-dental services:

- *Schedule of Medical Benefits, 2001*;
- *Schedule of Oral and Maxillofacial Surgery Benefits, 2001*;
- Reports of the Auditor General of Alberta for 1999-2000 and 2000-2001.

Office consolidations of all health care insurance legislation, as identified under the public administration section of our narrative, together with all relevant regulations:

- *Alberta Health Care Insurance Act*;
- Alberta Health Care Insurance Regulation;
- *Government Accountability Act*;
- *Health Care Protection Act*;
- Health Care Protection Regulation;
- *Health Insurance Premiums Act*;
- Health Insurance Premiums Regulation;
- Hospitalization Benefits Regulation;

- *Hospitals Act*;
- Hospital Foundation Regulation;
- Medical Benefits Regulation;
- *Medical Profession Act*;
- *Nursing Homes Act*;
- Nursing Homes General Regulation;
- *Regional Health Authorities Act*;
- Regional Health Authorities Regulation;

Reports giving recognition to federal contributions provided under the Canada Health and Social Transfer (CHST):

- *Alberta Health Care Insurance Plan Statistical Supplement, 1999-2000*;
- *Alberta Ministry of Health and Wellness Annual Report, 1999-2000*;
- *Ministry of Health and Wellness Three-Year Business Plan, 2001-2004*;
- Alberta Budget, 2000-2001.

British Columbia

Introduction

British Columbia has a progressive and integrated health care system. The British Columbia health system includes insured services under the *Canada Health Act* as well as services funded wholly by the Government of British Columbia. It is based on regional delivery and self-regulating professional colleges providing quality, accessible and affordable health care. Health authorities are responsible for the delivery and management of health services in each community of British Columbia. As of March 31, 2001, the health authorities included 11 Regional Health Boards, 34 Community Health Councils and 7 Community Health Services Societies across the Province. Health care is a top priority for the Government and people of British Columbia. The delivery of health care in the Province includes wholly and partially funded health services, as well as services regulated but not funded by the Government.

Activities for 2000-2001

During 2000-2001, the Ministry of Health focussed on ensuring the delivery of timely, quality health services in British Columbia. A critical issue in this regard was keeping the health system supplied with doctors, nurses and other care providers where they were needed. The provincial health system also focussed on meeting the needs of an aging population and developing innovative ways of meeting the increasing requirements for a system that is responsive to, and respectful of, seniors. The need to meet these challenges led the Government to build stronger partnerships among the Ministry of Health, health authorities and key stakeholders and to find new and effective ways of delivering the high quality, accessible care that people need.

A number of measures were undertaken in 2000-2001 to improve access and to reduce waiting times for insured hospital services. Utilizing in part monies received from the federal government, British Columbia acquired 15 CT scanners and 11 MRI scanners. This brings the total number of MRI scanners from 7 to 16, more than doubling the Province's capacity.

A wide range of capital projects were funded to provide new and improved health care facilities.

Changes in 2001-2002

On June 5, 2001, the Ministry of Health and Ministry Responsible for Seniors was reorganized into two new ministries to meet health challenges and to enhance health care in British Columbia. The Ministry of Health Services provides funding, strategic direction and leadership to support the delivery of health care, preventive health and health promotion services in British Columbia. The Ministry of Health Planning supports the development of long-term planning necessary to sustain British Columbia's public health care system in the years ahead.

Information on health and health care in British Columbia is available from the following websites:

www.gov.bc.ca/healthservices/

www.gov.bc.ca/healthplanning/

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, by the Regional Programs Division of the Ministry of Health. This program is responsible to the provincial

government for the ongoing funding of the Province's public hospitals, delivered via funding and transfer agreements with regionalized health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act*, and the *Hospital District Act*. This entails expenditures and commitment controls for the operation of hospitals (amalgamated and non-amalgamated) and designated facility societies, provision of funds for hospital construction and equipment, and payment of out-of-province hospital costs for qualified British Columbia residents.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health Services and facilitates, in the manner provided for under the *Medicare Protection Act* (1996), reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is carried out by the employees of the Medical Services Plan program of the Ministry of Health Services.

The Commission's powers include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, negotiating agreements with practitioners and their associations, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing or investigating practitioner billings and patterns of practise concerning claims submitted, and hearing appeals from practitioners and beneficiaries.

1.2 Reporting Relationship

Health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health in accordance with provincial policy. Non-amalgamated hospitals are required to report health information data to the Ministry of Health in accordance with provincial policy, and to their health authority as requested by the health authority. The Regional Programs Division reports to government through the *Ministry of Health Annual Report*.

The Medical Services Commission reports annually to the Minister in a separate Financial Statement. The statement is included in the *Ministry of Health Annual Report* to government. The 1999-2000 Annual Report was tabled February 9, 2001.

In its annual performance report, the Ministry of Health provides extensive information on the performance of B.C.'s publicly-funded health care system. Tracking and reporting this information is consistent with the Ministry's increasingly strategic approach and its responsibilities for performance planning and reporting, under the *Budget Transparency and Accountability Act*.

1.3 Audit of Accounts

The Regional Programs Division and the Medical Services Commission are subject to audit of their accounts and financial transactions through three types of auditor. Internally, the Ministry of Health Financial Policy and Monitoring Branch reviews Ministry operations.

The Office of the Comptroller General's Internal Audit Branch is the provincial government's internal auditor and the Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the findings. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry of Health. The Ministry's Senior Financial Officer determines the scope and timing of reviews conducted by the Financial Policy and Monitoring Branch.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided in facilities specified in the *Hospital Insurance Act*. In 2000-2001 there were 94 acute care hospitals, 3 rehabilitation hospitals, 18 free-standing extended care hospitals and 25 diagnostic and treatment and other health centres.

Insured in-patient services provided by hospitals are:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister;
- clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the Hospital Insurance Act;
- routine surgical supplies;
- use of operating room and case room facilities;
- anaesthetic equipment and supplies;
- use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- other services approved by the Minister that are rendered by persons who receive remuneration from the hospital.

Qualified persons not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Hospital out-patient benefits include:

- out-patient renal dialysis treatments in designated hospitals or other approved facilities;
- diabetic day-care services in designated hospitals;
- out-patient dietetic counselling services at hospitals with qualified staff dieticians;
- psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day care services;
- cancer therapy and cytology services;
- out-patient psoriasis treatment;
- abortion services; and
- MRI services.

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

Ambulance services are provided within the Province by the British Columbia Ministry of Health through the Emergency Health Services Commission, with a nominal charge to the patient.

In 2000-2001, no new services were added to the list of insured hospital services covered by the *Hospital Insurance Act*.

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act (1996)*. The Medical Services Plan provides for all medically required services of medical practitioners. The broad category of services covered includes consultations; complete examinations; home visits; major and minor surgery; obstetric services; surgical assistance; anaesthesia; diagnostic/therapeutic procedures; special and miscellaneous services; other office procedures; and other hospital procedures performed by a physician.

To practise in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the Medical Services Plan. There were 7,658 physicians

enrolled and billing fee-for-service in the fiscal year 2000-2001 as of March 2001. In addition, some physicians practice solely on salary or receive sessional payments under alternative payments. Most physicians paid by alternative mechanisms also practise on a fee-for-service basis.

A physician can choose not to enroll or to de-enroll with the Commission. An enrolled physician can cancel their enrolment by giving 30 days' written notice to the Commission. Services provided by un-enrolled physicians are not benefits and patients are responsible for the full cost of the service.

There was one previously enrolled physician who had de-enrolled as of March 31, 2000.

Enrolled physicians can elect to be paid directly by beneficiaries by giving written notice to Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries can apply to the Medical Services Plan for reimbursement of the fee for insured services rendered. Only eight physicians have opted out as of March 2001.

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental or oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan who is providing one or more of the limited insured dental surgical services in a hospital may provide an insured dental-surgical service. There were 283 dental surgeons and three oral surgeons enrolled in 2000-2001. None have de-enrolled and none have opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are:

- diagnostic out-patient services not associated with emergency services;
- the services of medical personnel not employed by the hospital;
- treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
- services solely for the alteration of appearance; and
- reversal of sterilization procedures.

Uninsured hospital services also include:

- preferred accommodation at the patient's request;
- televisions, telephones and private nursing services;
- preferred medical/surgical supplies;
- dental care that could be provided in a dental office including prosthetic and orthodontic services; and
- preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan are:

- those covered by the *Workers' Compensation Act* or by other federal or provincial legislation;
- provision of non-implanted prostheses;
- orthotic devices;
- proprietary or patent medicines;
- any third-party request for a medical examination or certificate;
- oral surgery rendered in a dentist's office;
- acupuncture;
- group immunizations;
- telephone advice;
- reversal of sterilization procedures;
- *in-vitro* fertilization;
- medico-legal services;

- cosmetic services; and
- preventive medical counselling, for example, smoking withdrawal programs.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services. The status of the patient as a beneficiary of a third-party payer should not affect this determination. In this way, third parties are not given priority access to insured services over insured persons.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the Act prohibits persons from charging a beneficiary "for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry of Health responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee.

3.0 Universality

3.1 Eligibility

For insured hospital services the eligibility terms and requirements are set out in the *Hospital Insurance Act*, sections 2, 3, 4, 6, and 7 and the Hospital Insurance Act Regulations sections 1, 3, 4 and 9.3. Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry's Acute Care Policy Manual.

The *Medicare Protection Act* defines the eligibility and enrolment of beneficiaries of insured physician services. The Act's regulations (Medical and Health Care Services Regulations) detail residency requirements in Part 2. A person must be a resident of British Columbia in order to qualify for provincial health care benefits. The *Medicare Protection Act* defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under the Regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage.

The Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

As of April 1, 1998, residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enroll. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the Province. Each person who enrolls with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrolment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries may cover their dependants, provided the dependants are residents of the Province. Dependants include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward under the age of 19 supported by the beneficiary, or a child under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2000 was 4.02 million. Enrolment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2001, 150 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible. Individuals who are approved for refugee status and who are, therefore entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits. Holders of Minister's Permits are eligible for benefits where deemed to be residents under the Medical and Health Care Services Regulation. A waiting period applies.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for the Medical Services Plan are $36 for one person, $64 for a family of two, and $72 for a family of three or more. Residents with limited means may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident status (landed immigrant).

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2001 the maximum non-subsidized rate was $50 a day. Residents with limited means are eligible for assistance, on a sliding scale, being 85 percent of the Old Age Security and Guaranteed Income Supplement. In certain circumstances there is a provision to waive a portion of the $25.90 fee. Client rates of less than $50 per day are reviewed quarterly and patients are advised one month before any changes are made.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a resident.

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions during temporary absences from British Columbia but still residing within Canada with regard to insured physician services. Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province or territory to

bring about a high degree of liaison and cooperation between the provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the Province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their home in British Columbia. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). British Columbia then reimburses the Province or territory at the rate of the fee schedule in the province or territory in which services were rendered.

For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the inter-provincial and inter-territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though inter-provincial and inter-territorial reciprocal billing procedures.

The Financial Administration section of the Acute Care Policy Manual sets out the specific details of the current inter-provincial or territorial reciprocal billing agreement for insured hospital services. Each provincial hospital insurance plan will process hospital in-patient and out-patient accounts on behalf of the residents of the other provinces and territories, with the exception of Quebec, which is not a signatory to the Agreement. The Agreement covers benefits rendered within provincial or territorial boundaries and makes provision for the periodic settling of accounts between provinces and territories.

4.3 Coverage During Temporary Absences Outside Canada

The *Hospital Insurance Act* Regulations and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until the last day of the month in which the person ceased full-time attendance at that educational institution, or if studying outside Canada, the last day of the sixtieth month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence, if this person obtains prior approval from the Commission, does not establish residency outside BC and has not been granted approval for a similar absence during the preceding 60 months.

With prior authorization, coverage is provided for hospital services not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Renal dialysis day care is available at the inter-provincial and inter-territorial Canadian rate. In all other cases, including emergency or sudden illness during temporary absences from the Province, in-patient hospital care is paid up to $75 Canadian per day for adults and children, and $41 Canadian per day for newborns.

Out-of-country medical services are covered for emergency or sudden illness during temporary absences from the Province. These are paid up to the same fee payable for that service, had it been performed in British Columbia. Cases

pre-authorized because of extenuating circumstances, however, are paid at the rate applicable where the service is rendered. With prior authorization, payment for non-emergency medical services outside the country may be made at usual and customary rates, when the appropriate treatment is not available in the Province or elsewhere in Canada.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the inter-provincial reciprocal agreements with other provinces. Prior approval from the Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of Regional Programs (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require approval from the Commission prior to the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes that all residents have reasonable access to hospital and medical care services. Beneficiaries, as defined in the *Medicare Protection Act* and the Ministry's Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, section 17, prohibits extra-billing for medical services provided by enrolled physicians.

5.2 Access to Insured Hospital Services

In 2000-2001, there were 8,994 acute care beds in 94 acute care facilities, and 474 rehabilitation beds, of which 176 were located in three specialized rehabilitation care facilities. In addition, there were 25 diagnostic and treatment centres and six Red Cross Outposts.

The Province also provides access to care services for extended care patients. In 2000-2001, there were 17 free-standing extended care facilities. These care units and the associated beds in acute/rehabilitation hospitals provided a total of 9,102 extended care beds.

The number of practising Registered Nurses as of December 2000 was 28,616. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2000 there were 2,203 RPNs and 4,496 LPNs.

The "Capital Planning Requirements for Health Authorities" document defines the Ministry of Health's expectations of health authority capital planning. This document outlines the processes, policies, timelines, and roles and responsibilities related to health capital projects. The requirements apply to all types of health care facilities, community health centres, ambulance stations, and mental health facilities.

Capital planning needs to be consistent with the health authorities' visions, missions, needs assessment, priority issues, goals and strategies as outlined in their three-year health service plans. The health service plan, combined with the age and condition of the components of a health authority's physical inventory, will determine the direction for capital planning in a health authority area. Health Authorities submitted Capital Plans in June 2000 for the three-year period 2001-2004. The Capital Plans include the anticipated capital requirements for the three-year period within the context of the strategic direction of each health authority.

Government responsibility for health capital projects is shared between the Ministry of Health and the Ministry of Finance and Corporate Relations. The Ministry of Health is responsible for needs assessment and planning, while the Implementation Branch of the Ministry of Finance and Corporate Relations is responsible for project management, financial administration, and project delivery.

Regional hospital districts cost-share with the provincial government for a portion of the capital costs associated with health facilities that operate under the authority of the *Hospital*

Act. This contribution comes from taxpayers via property taxes levied by regional hospital district boards composed of municipal and electoral area directors under the authority of the *Regional Hospital District Act*.

A number of measures were undertaken in 2000-2001 to improve access and to reduce waiting times for insured hospital services. Utilizing in part monies received from the federal government, British Columbia acquired 15 CT scanners and 11 MRI scanners. This brings the total number of MRI scanners from 7 to 16, more than doubling the Province's capacity.

A wide range of capital projects were funded to provide new and improved health care facilities for British Columbians. Major projects undertaken by the Ministry of Health in the 2000-2001 fiscal year include the following:

- The B.C. Cancer Agency's new Vancouver Island Cancer Centre opened in March 2001. The new centre adds 20 percent more treatment capacity for Island residents and reduces service pressures in other cancer centres in the Province. The Ministry of Health contributed $39.3 million to build and equip the new centre. The Ministry also provided $1.9 million in start-up costs and $400,000 in one-time operational funding to enable the centre to open early, upon completion of construction.
- A new wing and children's health centre opened at Surrey Memorial Hospital. The new wing increases the number of operating rooms, in-patient beds and special-care basinettes in the nursery. The Ministry of Health provided total funding of $76.5 million required to complete the hospital addition.
- The new Ambulatory Care Building at B.C. Children's Hospital was under construction during the 2000-2001 fiscal year.
- Construction began to expand and redevelop the Prince George Regional Hospital. This project includes building a four-story medical surgical tower, adding more out-patient services, expanding the haemodialysis and paediatric units, and upgrading the emergency department.
- Work began at Trail Regional Hospital to expand ambulatory care facilities. The new $6.7 million unit will enable the hospital to deliver a wide range of out-patient services, including surgical day care, a surgical suite and an expanded emergency area.
- Work began on the $3.5 million renovation and expansion project at Golden and District General Hospital. Improvements to the hospital will include expanding and redeveloping emergency and main entry areas, as well as major mechanical and electrical upgrades.
- Eagle Ridge Manor, a new multi-level care addition to the Port Hardy Hospital, opened in July 2000. The manor will provide 24-hour care to residents in a home-like setting.
- Construction started on the new $5.6 million Cormorant Island Health Centre that will replace St. George's Hospital in Alert Bay. The centre will provide acute care and multi-level-care beds, diagnostic and treatment facilities, community health programs and support services.

Additionally, the Province has introduced the HealthGuide program. Initially, the Health Guide manual has been distributed to every household in British Columbia. Supporting this health user manual is an online knowledge base available to all persons with a BC personal health number, and a nurse line is available 24 hours a day, 7 days a week, toll-free throughout British Columbia.

5.3 Access to Insured Physician and Dental-Surgical Services

There were 4,360 General Practitioners, 3,298 Specialists and 283 Dentists who provided insured fee-for-service physician and dental-surgical services in 2000-2001.

The Ministry of Health initiated a Physician Recruitment and Retention Program to address workload and practice issues of doctors working in rural and remote areas of BC. Changes made to the Physician Recruitment and Retention Program included developing a new payment program for rural physicians. Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an

estimated 1,728 visits by family doctors and specialists to 61 rural communities. The Northern and Rural Locum Program assisted physicians practising in small communities to secure subsidized continuing medical education and vacation relief.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medial Association to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including salaried physicians. Other health care practitioners offering insured services have individual fee schedules approved by the appropriate special committees.

The Master Agreement between the Medical Services Commission, the Government of British Columbia and the British Columbia Medical Association, signed in December 1993, was extended until March 31, 2001. Key elements include a binding dispute resolution mechanism and participation by the Association and the Commission.

During 2000-2001, the Medical Services Plan's payments to physicians, supplementary benefit practitioners and program management in the Province totaled approximately $1.62 billion. For physician services provided out-of-province, including those within Canada and outside the country, the Plan paid approximately $35.8 million, of which approximately $4.5 million was for reciprocal payments to other provinces or territories.

Payment for medical services delivered in the Province is made through the Medical Services Plan to individual physicians, based on billings submitted. The patient is not normally involved in the payment system. Ninety-eight percent of claims are submitted electronically through the Teleplan System, while the remaining two percent are submitted on claim cards by low-volume physicians and other health care practitioners.

The Medical Services Commission also funds certain medical services through alternative payment arrangements. An Alternative Payments Branch provides funding to some 360 health care agencies that retain physicians to deliver approved programs. Approximately 1,900 physicians have voluntarily entered into alternative payment arrangements with these agencies, and receive part or all of their income through salaries, sessions or service agreements. A variety of alternative payment arrangements are currently being explored, including population-based funding for family practice.

5.5 Payments to Hospitals

In 2000-2001, the total funding provided to Health Authorities was $4.8 billion, including funds for hospital, continuing care, health promotion and preventive health, and adult mental health programs. Payments to out-of-province hospitals, including those within Canada and outside the country, for insured services provided to British Columbia residents, totalled $4.5 million in 2000-2001.

6.0 Recognition

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of British Columbia through a various government websites and provincial government documents. For the fiscal year 2000-2001, these documents included the following:

- Public Accounts for 1999-2000 (Tabled August 14, 2000);
- Public Accounts for 2000-2001 (Tabled July 31, 2001);
- Budget 2001 (Tabled March 15, 2001);
- Ministry of Health and Ministry Responsible for Seniors Performance Plan 2000-2001 (Tabled April, 2000);
- *Ministry of Health and Ministry Responsible for Seniors Annual Report 2000-2001* (Tabled June, 2001).

7.0 Extended Health Care Services (EHCS)

The Regional Programs of the Ministry of Health fund a comprehensive range of community-based supportive care services to assist people whose ability to function independently is affected by long-term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, community home nursing care, physical therapy, occupational therapy, dietician counselling, social worker services, and meals programs); residential care services (family care homes, group homes, personal intermediate and multi-level care homes, private hospitals, extended-care units); and special support services (adult day centres, respite care, and assessment and treatment centres). Services are delivered at the community level through the health authorities.

Residential care services provide care and supervision in a protective, supportive environment for adults who can no longer be looked after in their own homes.

Community home-nursing care services provide professional nursing care to people of all ages in their own homes. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination, and direct nursing care for clients requiring chronic, acute, palliative or rehabilitative services.

Home support services provide non-professional assistance with personal care and housekeeping, and adult day centres offer a centre-based program of health, social and recreational activities.

Yukon

Overview

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director of Insured Health Services. References in this text to the "Plan" refer to either the YHCIP or the Yukon Hospital Insurance Services Plan.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services in accordance with the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory. The Minister, Department of Health and Social Services, is responsible for the delivery of all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services, Insured Health Services and Community Health Programs. There are no regional health authorities. There were 31,133 eligible persons registered with the Yukon health care plan on March 31, 2001.

Other legislated insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program, Chronic Disease and Disability Benefits Program; Pharmacare and Extended Benefits Programs; and the Children's Drug and Optical Program. Other non-insured programs include Public Health, Ambulance Services, Hearing Services, Health Promotion, Dental Health and Mental Health Services.

One of the major challenges facing the delivery of insured health care services in the Territory is the recruitment and retention of health care professionals such as general practitioners, specialists and nurses. The increasing cost of retaining health care professionals, operating hospitals and acquiring and maintaining new and advanced high-technology diagnostic and communication services has a direct impact on the ability of the Government of the Yukon to maintain or improve the existing level of services available to eligible residents.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, adopted April 1, 1972, sets out the legislative framework for the payment of insured physician services to eligible Yukon residents. The *Hospital Insurance Services Act*, adopted April 9, 1960, sets out the legislative framework for payment to hospitals i.e., amounts in respect of the cost of insured services provided by hospitals to insured persons.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate and function of the Director, Insured Health Services is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in the operation of the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of the

Yukon's right of subrogation under this Act to the rights of insured persons;

- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health Services is to:

- develop and administer the hospital insurance plan;
- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research programmes and obtain statistics for such purposes;
- appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
- prescribe the forms and records necessary to carry out the provisions of this Act; and
- perform such other functions and discharge such other duties as may be assigned by the Regulations.

There were no amendments made to the Legislation in 2000-2001.

1.2 Reporting Relationship

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health Services make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and is subject to discussion at that level.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report tabled in December 2001 covered the fiscal years 1998-1999, 1999-2000 and 2000-2001.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Auditor General's office. The Auditor General of Canada is the auditor of the Government of the Yukon in accordance with section 30 of the *Yukon Act* (Canada) and section 8(4)(e) of the *Financial Administration Act* (Yukon). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit was for the year ended March 31, 2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9 and sections 2, 4, 5, 9 and 11 of the Hospital Insurance Services Regulations, provide for insured hospital services. There were no amendments made to the Legislation in 2000-2001.

In 2000-2001, insured hospital services to in-patients and out-patients were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital[1] and twelve health centres[2]. Visiting nursing services are provided in one health station[3].

All services provided in a hospital by hospital employees are insured. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services.

Pursuant to the Hospital Insurance Services Regulations, section 2(e) and (f), services provided in an approved hospital are insured services. Section 2(e), defines "in-patient insured services" as all of the following services to in-patients, namely:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability;
- drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- use of radiotherapy facilities where available;
- use of physiotherapy facilities where available; and
- services rendered by persons who receive remuneration therefor from the hospital.

Section 2(f) of the same regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator provided the service could not be obtained within 24 hours of the accident, namely:

- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations of the purpose of assisting in the diagnosis and treatment of an injury;
- drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
- use of operating room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- services rendered by persons who receive remuneration therefor from the hospital;
- use of radiotherapy facilities where available; and
- use of physiotherapy facilities where available.

2.2 Insured Physician Services

Adopted on April 1, 1972, sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 4, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to the Legislation in 2000-2001.

The Yukon Health Care Insurance Plan covers physicians who provide medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are that they must:

- register for licensure pursuant to the *Medical Professions Act*, and

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1 A facility that provides 24-hour emergency treatment, short-term admissions and respite care.

2 Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

3 A facility that serves as a clinic from which Community Nurse Practitioners provide services on a regularly scheduled basis.

- maintain licensure pursuant to the *Medical Professions Act*.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations states that "A medical practitioner may elect to collect his fees under the Plan for insured services rendered to insured persons otherwise than from the Plan without loss of benefit to insured persons by giving notice in writing of his election". In 2000-2001, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations (see section 2.4). Services not covered by the Plan include advice by telephone, medical-legal services, preparation of records and reports, services required by a third party, cosmetic services, and services determined to be not medically required.

During the period April 1, 2000 to March 31, 2001 the following services were added to the list of insured physician services covered by the Yukon Health Care Insurance Plan:

- management of prolonged second stage of labour (fee code 4199);
- repair of complete separation of external sphincter (fee code 4022);
- repair of extensive cervical and/or vaginal lacerations (fee code 4023);
- rheumatology consultation (fee code 3101);
- rheumatology repeat limited consultation (fee code 3102); and
- rheumatology office visit (fee code 3103).

The process used to add a physician service to the list of insured services covered by the Yukon Health Care Insurance Plan requires that physicians submit in writing a request to have a fee code added to the Relative Value Guide to Fees[4]. The request is then reviewed by the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee. Following review, a decision is made on whether to include or exclude the service. The costs or fees are normally set in accordance with costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. No public consultation is required in this process.

[4] Physician's fee guide manual.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the territory must be licensed pursuant to the *Dental Professions Act* and are provided billing numbers for the purpose of billing the Yukon Health Care Insurance Plan for the provision of insured dental services. In 2000-2001, six dentists, three oral surgeons and two orthodontists billed the Plan for insured dental services. No dentists opted out of the Yukon Health Care Insurance Plan in 2000-2001.

Insured dental services are limited to those surgical-dental procedures scheduled in the Regulations and requiring the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia). Insured surgical-dental services include:

- surgical removal of unerupted teeth;
- alveoloplasty and gingivolplasty;
- sulcus deepening and ridge construction;
- exposure of tooth for orthodontic treatment;
- treatment of traumatic injuries to soft tissues within the mouth;
- root resection;
- phrenectomy;
- excision of intra-oral cysts;
- excision of benign intra-oral tumours;
- sialolithotomy;
- excision of ranula;
- condylectomy;
- intra-oral biopsy;
- incision and drainage of abscess of dental origin;

- closed reduction of fractures of mandible and maxilla;
- open reductions of fractures of the mandible and maxilla;
- closed reduction of temporo-mandibular dislocation;
- open reduction of temporo-mandibular dislocation;
- removal of root or foreign body from maxillary antrum;
- repair and closure of antro-oral fistula;
- surgical correction of prognathism or micrognathia;
- therapeutic or diagnostic alcohol nerve block; and
- avulsion of nerve (mental, infra-orbital or interior dental).

In the case of children aged 16 years or under, the following surgical-dental services are also insured:

- oral surgery and orthodontia necessitated by, or consequent to the repair of, cleft palate or cleft lip deformity, only where that service arises as part of or following plastic surgical repair;
- surgical removal of erupted, unerupted or impacted teeth; and
- such other dental care procedures as determined to be medically necessary by the Director of Insured Health Services.

The addition of new surgical-dental services to the list of insured services requires amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured. See "Additional Materials" for a complete listing.

Uninsured physician services include:

- services that are not medically necessary;
- charges for long-distance telephone calls;
- preparing or providing a drug;
- case conference;
- advice by telephone at the request of the insured person;
- medico-legal services including examinations and reports;
- cosmetic services;
- acupuncture;
- experimental procedures.

Section 3 of the Yukon Health Care Insurance Plan Regulations contains a non-exhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include non-resident hospital stays; additional charges for preferred accommodation unless prescribed by a physician; private nursing charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services are services considered to be restorative.

All Yukon residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Health and Safety Board are not given priority access to services. The Territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health Services to monitor usage and service concerns.

The purchase of non-insured services such as fibreglass casts does not delay or prevent access to insured services at any time. Insured persons are provided treatment options at the time of service. The territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health Services to monitor usage and service concerns.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows.

- **Physician services** - the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service all physicians are provided notification in writing. The Director, Insured Health Services manages this process.
- **Hospital services** - an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2001, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. The Director, Insured Health Services is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- **Dental-surgical services** - an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required.

No services were removed from the Relative Value Guide to Fees in fiscal year 2000-2001.

3.0 Universality

3.1 Eligibility

For insured hospital services the eligibility terms and requirements are set out in the *Health Care Insurance Plan Act*, section 2; the *Health Care Insurance Plan Act* and Regulations, section 4; the *Hospital Insurance Services Act*, section 2; and the *Hospital Insurance Services Act* and Regulations, section 4. Subject to the provisions of these Acts and their regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and "means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon."

Under section 4.(1) of both health care insurance regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory."

Residents ineligible for coverage are those residents who are entitled to or eligible for benefits under any other act, under any law of a province or under any act of the Canadian Parliament other than the *Canada Health Act*, are not entitled to benefits. This includes but is not limited to members of the Canadian Forces; members of the Royal Canadian Mounted Police (RCMP); and inmates in federal penitentiaries.

Persons who provide documentation indicating the date of discharge or release from the RCMP, armed forces or a federal penitentiary become eligible for coverage under the Yukon Health Care Insurance Plan on the day following the documented date.

3.2 Registration Requirements

Persons moving to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form, which is available from the Insured Health Services office or community Territorial Agents. Once approved, a health care card is mailed to the applicant. Family members receive separate health care cards and numbers. Coverage expires every year on the resident's birthday and an updated label, with the new expiry date is mailed out each year.

If other family members move to the Yukon in advance of a remaining spouse residing elsewhere in Canada, the originating province or territory will cover all family members to a maximum of 12 months, in accordance with the Interprovincial Agreement on Eligibility and Portability.

As of March 31, 2001, there were 31,133 residents registered with the Yukon Health Care Insurance Plan.

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the regulations from so doing, shall register himself and his dependants with the Director, Insured Health Services, at the place and in the manner and form and at the times prescribed by the regulations."

3.3 Other Categories of Individual

Conditions regarding eligibility for coverage applying to special categories of individuals are as follows:

- returning Canadians and landed immigrants: no waiting period (section 4(3) Yukon Health Care Insurance Plan Regulations and section 4(3) Yukon Hospital Insurance Services Regulations);
- authorized Minister's Permit: no waiting period if eligible;
- Convention Refugees: eligible if the individual has an Employment Authorization for one year; and
- authorized Temporary Residents (e.g., Employment Authorizations and permits other than Minister's permits: no waiting period).

There were four individuals residing in the Yukon with work visas as of March 31, 2001.

3.4 Premiums

Yukon residents pay no premiums.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to the Yukon from another province or territory are entitled to coverage pursuant to section 4.(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations. Section 4.(1) states that "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

4.2 Coverage During Temporary Absences In Canada

The provisions relating to portability of health care insurance during temporary absences in Canada are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies (confirmation of registration is required yearly). The Director, Insured Health Services may approve other absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director. For temporary workers, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. For missionaries, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt

of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health Services.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability effective January 1, 1998. Definitions have been rendered consistent in regulations, policies and procedures.

Yukon participates fully with the Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories (Quebec does not participate in the medical reciprocal billing arrangement). Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 2000-2001.

In-patient services	Out-patient services
$4,220,525	$857,580

Note: figures are by date of service and are not final[5]

In 2000-2001 payments to out-of-territory physicians totalled $1,660,572. (Includes out-of-Canada costs and is by payment date.)

The Hospital Reciprocal Billing Agreements provide payment of in-patient and out-patient hospital services to eligible Yukon residents receiving insured services outside the territory. High-cost procedure rates, newborn rates and out-patient rates are derived by the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing. These rates are established by Order-in-Council under the Charges for Out-Patient Procedures Regulation, Standard Ward Rates Regulation and Charges for In-Patient High-Cost Procedures Regulation.

The Medical Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Yukon residents receiving insured services outside the Territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

Sections 5 and 6 state that "Where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

The provisions for portability of health insurance during out-of-country absences are similar to those in effect for absences within Canada as described under section 4.2. Similar provisions also apply for out-of-country students, temporary workers and missionaries.

Students attending educational institutions outside the territory remain eligible for the duration of their academic studies (confirmation of registration is required yearly). With regard to temporary workers, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. For missionaries, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. All requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health Services.

[5] Out-of-country costs are reported under lines 22 and 23 in the Yukon section of Annex A – Provincial and Territorial Health Care Insurance Plan Statistics.

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in the Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. Reimbursement is made for elective and emergency services. Exceptions may be made where the services received are not available in Canada. Remuneration is based on the standard ward rate of the nearest approved facility in Canada providing similar services. Prior approval is required. The standard ward rate for the Whitehorse General Hospital as of March 31, 2001 was $989. The rate is established through Order-in-Council and is derived as follows:

- Standard Ward Rate = (total operating expenses - non-related in-patient costs - related newborn costs - associated out-patient costs) / (total patient days - patient days for other services, ex. non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $110 and is established through Order-in-Council and is derived by the Canadian Coordinating Committee on Reciprocal Billing (CCRB).

The following amounts were paid for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
$20,597	$8,368

Note 2000-2001 figures are by service date and are not final

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency services outside Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. Access to specialists and services not available locally are available through a visiting medical specialist program and a publicly funded travel for medical treatment program. There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Hospital beds are readily available and no wait-list for admission exists. The Yukon's main acute-care facility, the Whitehorse General Hospital, is located in Whitehorse. Beds staffed and in operation as of March 31, 2001 totaled 49. Eight additional acute care beds can be made available, should future occupancy trends indicate a need. The Yukon has no rehabilitative beds. Patients are referred out-of-territory for these services – usually to Vancouver or Edmonton.

The Whitehorse General Hospital currently employs 103 nurses, representing 72¾ full-time equivalent (FTE) positions. A full complement requires 75¾ FTE positions.

The Whitehorse General Hospital provides in-patient, out-patient, and 24-hour emergency services. Emergency services are provided on rotation by local physicians. Medical services provided include:

- intensive care services (surgical and cardiac);
- respiratory services (chronic obstructive pulmonary diseases, asthma etc.);
- cardio vascular accidents;
- maternity;
- gastro-intestinal bleeds;
- cellulitis;

- chemotherapy;
- hypertension, and
- general failure to thrive/weakness.

Surgical services provided include:

- minor orthopaedics;
- gynaecology;
- paediatrics;
- general abdominal;
- mastectomy;
- emergency trauma;
- ear/nose/throat/otolaryngology;
- ophthalmology including cataracts.

Patients requiring specialized surgeries are sent to outside centres.

Diagnostic services include:

- radiology;
- laboratory;
- mammography, and
- electrocardiogram.

Rehabilitative services are limited.

There is no wait-list for admission to the Whitehorse General Hospital. Emergency day surgery patients are normally seen within 24 hours. Non-emergency day and routine surgery patients are normally seen within one to two weeks. Visiting specialist clinics are routinely increased to reduce wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3). For services not available locally, the Visiting Specialist Program provides services and the Travel for Medical Treatment Program is available to assist eligible persons with the cost of medically necessary transportation for emergency and non-emergency insured services.

A second acute care facility is located in Watson Lake — the Watson Lake Cottage Hospital. There are 12 beds and there is no wait-list for admission.

Other than the Whitehorse General Hospital and the Watson Lake Cottage Hospital, only the Dawson Health Centre provides limited in-patient services. Out-patient and 24-hour emergency services are provided by all 12 community health centres. Health centres are staffed by one or more Community Nurse Practitioners and auxiliary staff. The communities of Whitehorse, Faro, Mayo, Watson Lake and Dawson City have resident physicians.

In April 1998 the Yukon departments of Health and Social Services and Government Services, together with NorthwesTel, successfully applied to the Canadian Network for the Advancement of Research, Industry and Education (CANARIE) for funding to pilot a telemedicine project in Dawson City, Ross River and Teslin. The purpose was to enable the departments to test the use of telemedicine in improving accessibility to medical services and thereby improving quality of care. The pilot began in July 1998 and was completed on June 30, 1999.

Based on the success of the 1998 telemedicine project, application for funding has been made to the Canada Health Infostructure Partnerships Program (CHIPP), to implement real-time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta. CHIPP recently approved $1 million in funding for this project, which will run from September 1, 2001 to March 31, 2003.

5.3 Access to Insured Physician and Dental-Surgical Services

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2001:

General Practitioners/Family Practitioners	43
Specialists	6
Dentists	11

The following specialists provide services under the Visiting Specialist Program:

Ophthalmology	1
Oncology	3
Orthopaedics	4
Internal Medicine	1
Otolaryngology	2
Neurology	1
Rheumatology	1
Dermatology	1
Dental Surgery	1
Infectious Disease	1
Child Psychiatrist	1

Visiting specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2001, the wait-list for non-emergency specialist services was estimated at:

Ophthalmology	0-6 months
Orthopaedics	6-12 months
Otolaryngology	8-10 months
Dental Surgery	2-3 months

Most physicians in the Yukon are located in Whitehorse. Outside Whitehorse only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two contracted physicians have been placed in the communities of Faro and Mayo.

A visiting physician program provides access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians who provide visiting services are compensated for lost practice time, mileage, meals and accommodation.

The Travel for Medical Treatment Program assists eligible residents with the cost of medically necessary transportation from rural areas to access physician and hospital services that are not available locally.

The Department of Health and Social Services and the Yukon Medical Association (YMA) are in discussion on strategies that will address the current need for physicians and locums in Yukon. Several options are under consideration.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, prior to entering negotiations with the YMA. The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department of Health and Social Services seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent negotiations were concluded on December 14, 1999. The resulting Memorandum of Understanding is effective from April 1, 1999 through March 31, 2002.

The Legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. Currently, two full-time rural physicians are compensated on a contractual basis and one physician providing visiting clinics in an outlying community is paid a flat sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital), through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated based on operational requirements and utilization projections for prior years. The current one-year contribution agreement is in effect to March 31, 2002.

In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded through a contribution agreement. The cottage hospital and all health centres are funded through the Yukon Government's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Hospital Insurance Services Plan Regulations. The legislation and regulations set out the legislative framework for payment to hospitals of amounts in respect of the cost of insured services provided by that hospital to insured persons.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon Territory has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2000-2001 annual Main Estimates and Public Accounts publications, which are available publicly to Yukon residents.

7.0 Extended Health Care Services

Extended Health Care Services are available to eligible Yukon residents. In 2000-2001, the Yukon provided the following range of extended health care services:

- nursing home intermediate care services;
- adult residential care services;
- home care services; and
- ambulatory health care services.

The following details the types of services provided by facility and program:

MacDonald Lodge
- adult residential care
- home care

Macaulay Lodge
- nursing home intermediate care
- home care

Thompson Centre
- nursing home intermediate care
- ambulatory health care
- home care

Yukon Home Care Program
- home care
- ambulatory health care

No major changes were made in the administration of these services in 2000-2001.

In addition to the services described above, the following are also available to eligible Yukon residents:

The Chronic Disease and Disability Benefits Program: provides benefits for Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medical-surgical supplies and equipment. (Chronic Disease and Disability Benefits Regulation)

The Pharmacare Program and Extended Benefits Programs are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services, and medical-surgical supplies and equipment. (Pharmacare Plan Regulation and Extended Health Care Plan Regulation)

The Travel for Medical Treatment Program assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation. (*Travel for Medical Treatment Act* and Travel for Medical Treatment Regulation)

The Children's Drug and Optical Program is designed to assist low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 years of age and younger. (Children's Drug and Optical Program Regulation)

Public Health is designed to promote health and well-being throughout the territory through a variety of preventive and education programs. This is a non-legislated program.

The Ambulance Services Program is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non-legislated program.

Hearing Services provides services designed to help people of all ages with a variety of hearing disorders, through the provision of routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.

Dental Services provides a comprehensive diagnostic, preventative and restorative dental service to children from pre-school age to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for pre-school age to grade 12. This is a non-legislated program.

Mental Health Services provides assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. This is a non-legislated program.

Additional Materials Submitted to Health Canada

Lists of uninsured hospital, physician and surgical-dental services

- *Health Care Insurance Plan Act* and Regulations
- *Hospital Insurance Services Act* and Regulations
- Statement of Revenue and Expenditures: Health Care Insurance Programs
- Yukon Public Accounts – Excerpt of the Auditor General's Report, 1998-1999
- Yukon Public Accounts – Excerpt of consolidated Financial Statements, 1998-1999
- Yukon Budget, 2000-2001

Northwest Territories

Overview

The Northwest Territories Department of Health and Social Services, together with nine health and social services boards, offer a broad range of programs and services in family support, child protection, public health, home care, independent living, community wellness, environmental health, vital statistics insured services and supplementary health benefits. While insured services include medical care and hospital care, there are a number of other supplementary benefits such as pharmacare, medical travel and extended medical benefits for seniors. The NWT Department of Health and Social Services takes a community-based approach to service delivery. Health and Social Services boards deliver a full spectrum of community and institutional health services. Nurses are the largest group of health care practitioners in the Northwest Territories (NWT). In most communities, community health nurses are the access point to health care at community health centres. Health centres provide regular and emergency outpatient treatment services, a full public health program and consult with physicians as needed. Social workers provide community-based social services, including counselling, crisis intervention and child welfare programs.

In larger communities such as Yellowknife and Inuvik, physicians are often the public's first point of contact with the health care system. Other communities are visited regularly by a general practitioner and at times by a specialist.

Specialists are based at Stanton Regional Hospital in Yellowknife, or at hospitals in southern Canada. Stanton resident specialties include obstetrics/gynaecology, internal medicine, paediatrics, orthopaedics, ophthalmology, ear, nose and throat, radiology, general surgery and psychiatry. Special visiting clinics, such as urology and cardiology, offer additional consultant services for patients referred from outlying communities.

Changing Demographics

As of July 1, 2000, there were an estimated 42,083 people in the Northwest Territories, of which 21,320 were aboriginal people. The NWT has a relatively young population and a high birth rate. According to the 2000 census, approximately 27 percent of the NWT population is less than 15 years of age, compared with 19 percent in the overall Canadian population. This population profile points to a need to invest in services that target children, youth and young families.

Although the territorial population is comparatively young, it is nonetheless aging. By 2020, the number of seniors 65 years of age and older is expected to rise from approximately 1,700 to over 4,400, representing an increase of 160 percent. In contrast, the population under 20 years of age is expected to increase by only 15 percent over the same time period. On average, seniors require more health services than any other age group, including newborns. The demand for health resources among seniors is more than five times that of the population under 65. This relates to higher rates of cancer, circulatory diseases, nervous system and sense organ diseases, injuries and respiratory diseases compared with the population as a whole.

Changing Economic Conditions

Changes in the economic situation in the North have an impact on the health and well-being of residents. Income from increased employment opportunities, especially in the areas of mining and oil and gas exploration, has a positive impact on the economy. Increased disposable income can result in improved nutrition, safety, and security for families. However, changing economic conditions can also cause stress that may lead to an increase in social problems such as abuse of alcohol or gambling. Unstable employment is distressing and can affect physical, mental and social well-being. Studies have shown that the unemployed have a reduced life expectancy and suffer more health problems than the employed. In our smaller

communities, low household income levels and reduced employment opportunities combined with poor housing conditions create stress and unhealthy living conditions.

Incidence of Preventable Illness, Injury and Death

Compared with the rest of Canada, the incidence of preventable illness, injury and death is high in the Northwest Territories (*1999 Health Status Report*). Adverse outcomes such as family violence, Fetal Alcohol Syndrome/Effects (FAS/E) and most forms of cancer are linked to poor lifestyle choices made by individuals regarding diet or the use of alcohol, tobacco and drugs. Injuries and deaths are the result of risky behaviour. The underlying causes of many acute or long-term care needs are linked to poverty, low educational achievements, unemployment, and low self-esteem, all of which can lead to poor coping skills.

Tobacco use, in particular, has become an acute public health concern. Smoking rates in the NWT are among the highest in Canada. The implications for health care costs and human costs in terms of death and disability are significant and rising.

Rises in Health Care and Social Services Costs

Factors such as demographics, new technologies and medical practices, increased incidence of chronic and new diseases, use of recently developed and more expensive pharmaceuticals, and changing expectations of citizens have all contributed to an increased demand for resources.

In the Northwest Territories, population growth and inflation have also contributed to an increase in costs to deliver health and social services — in other words, delivery of the same set of core services this year costs more than it did last year. Increasing costs continue to place pressure on the system. The Government of the Northwest Territories can expect to face similar challenges.

Maintaining a Sustainable System

The delivery of health and social programs has been a subject of ongoing discussion in the Northwest Territories for a number of years. Change is required to address a number of significant challenges. These include concerns about the sustainability of the system in the face of limited resources and increasing demands, questions about the capacity of the current system to maintain quality of care, confusion about accountability relationships within the system, and challenges related to the coordination of service delivery. Difficulty in recruiting frontline professionals and the mounting competition from other jurisdictions across Canada and even internationally, places further strains on the system. A priority of the territorial government is to make sure programs and services are affordable and sustainable.

Information Technology

With a relatively small population distributed over a large and isolated area, the Northwest Territories is looking to new information technologies to improve connections between communities. At the same time, the remoteness of these communities makes it costly and difficult to provide adequate and appropriate technological solutions and to support those solutions once they are in place.

Data quality and integrity are a challenge in any jurisdiction, and are even more challenging in the NWT. It has become increasingly important that new information systems created for the Department and the Boards be developed with recognition of issues related to client privacy.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The name of the plan in the NWT is The Northwest Territories Health Care Plan, which includes the Medical Care Plan, and the Hospital Insurance Plan. The public authority responsible for the Medical Care Plan is the Director of Medical Insurance as appointed

under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through boards of management appointed under the *Hospital Insurance and Health and Social Services Administration Act*.

Legislation that enables the plan in the Northwest Territories includes the *Medical Care Act* (revised 1988) and the *Hospital Insurance and Health and Social Services Administration Act* (revised 1988). In January 2001, sections of the *Medical Care Act* Regulations pertaining to fee schedules were amended to reflect the negotiated contract between the NWT Medical Association and the Department of Health and Social Services.

The mandate of the Director of Medical Insurance is to deliver services as described in detail in the *Medical Care Act*. The mandate of the Minister is outlined in the *Health Insurance and Health and Social Services Act*.

1.2 Reporting Relationship

In the Northwest Territories, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for the administration of the *Medical Care Act* and the Regulations.

The Minister also appoints members to the Board of Management for facilities located throughout the Northwest Territories. Boards of Management are established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* or under the *Societies Act*. The Boards are established with the authority to manage, control and operate health and services facilities and, subject to the *Financial Administration Act* (1987), exercise any powers that are necessary and incidental to these duties. The Boards' Chairpersons hold office during the pleasure of the Minister, while the remaining members typically hold office for a term of three years, to a maximum of three consecutive terms. Accounts of the Boards of Management must be audited every year.

An annual audit of accounts is done at each Board of Management. The Chairperson of each Board of Management has regular meetings with the Minister, and uses that forum to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Auditor General of Canada has the mandate to audit the payments made under the Medical Care Plan. Pursuant to the *Financial Administration Act*, an auditor appointed by the Minister must audit the accounts of every Board of Management annually.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and the Regulations. As of March 31, 2001, the Northwest Territories had four hospitals and 28 health centres that delivered insured hospital services to both in- and out-patients.

The Northwest Territories provides a full range of insured hospital services. Boards of Management have the authority to provide services above those considered medically necessary, although those services are not covered by the insurance plans.

Insured in-patient services include accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and services rendered by an approved detoxification centre.

Out-patient services include laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital

services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy and speech therapy services in an approved hospital; and psychiatric and psychology services provided under an approved hospital program. A detailed list of insured in-patient and out-patient services is contained in the Territorial Hospital Insurance Services Regulations.

A detailed list of insured in-patient and out-patient services is contained in the Territorial Hospital Insurance Services Regulations. The Minister makes the determination to add insured hospital services to the Regulations. As such, on the recommendation of the Minister, the Commissioner may make regulations prescribing the in- and out-patient services that insured persons are eligible for and entitled to as insured services. The Minister will also determine if any public consultation will occur prior to making changes to the list of insured services.

Where insured services are not available in the Northwest Territories, residents receive those services from hospitals in other jurisdictions. These services must be medically necessary and they can include hospital-to-hospital transfer as well as referral from physicians. The NWT provides Medical Travel Assistance, a supplementary health benefit program, which ensures that residents of the NWT have accessed to medically required services.

2.2 Insured Physician Services

The *Medical Care Act* and the Medical Care Regulations provide for insured physician services in the Northwest Territories. Medical doctors are the only medical practitioners allowed to deliver insured physician services in the Northwest Territories. The physician must be licensed to practice in the Northwest Territories. Although physicians may opt out or de-enrol in the Northwest Territories, none have chosen to do so.

The Northwest Territories provides a broad range of medically necessary services. If a service has been deemed an insured service, no limitations are applied.

The Medical Care Plan insures all medically required procedures provided by medical practitioners, including approved diagnostic and therapeutic services; necessary surgical services; complete obstetrical care; eye examinations; and visits to specialists, even when there is no referral by a family physician.

In negotiations between the Northwest Territories Medical Association and the Director of Medical Insurance, additional medical services may be added to the fee schedule Regulation. The Director of Medical Insurance manages the process of adding a service and also determines if public consultations are appropriate before changes are made to approved schedules.

2.3 Insured Surgical-Dental Services

If the service is an insured service and related to oral surgery, injury to the jaw, or disease of the mouth/jaw, it is eligible. Only oral surgeons may submit claims for billing.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Some services provided by hospitals, physicians, and dentists that are not covered by the health care insurance plan of the NWT include medical-legal services, third-party examinations, services not medically required, group immunization, *in-vitro* fertilization, services provided by a doctor to his or her own family, telephone advice or prescriptions given over the phone, surgery for cosmetic purposes except where medically required, dental services other than those specifically defined services for oral surgery, dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, and surgical appliances or special bandages; treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act and Regulations*; physiotherapy and psychology services received from other than an insured

out-patient facility; services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and routine annual checkups where there is no definable diagnosis.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* is the legislation that defines the eligibility of Northwest Territories residents to the health care insurance plan of the Territory.

The Northwest Territories uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the Northwest Territories Health Care Plan Registration Guidelines to define eligibility. No changes have been implemented to eligibility in 2000-2001.

Ineligible individuals for Northwest Territories health care coverage are members of the Canadian Forces, Royal Canadian Mounted Police, federal inmates, and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form, and supporting documentation as applicable, e.g. visas and immigration papers. The individual must be prepared to provide proof of residency if requested. Registration should optimally occur prior to the actual eligibility date of the client. Renewal of health care cards is done every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of March 31, 2001, there were 41,673 individuals registered with the Northwest Territories Health Care Plan.

No formal provisions are in place for clients to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas, and in some cases visitor visas are covered if they hold valid visas for a period of 12 months or more.

4.0 Portability

4.1 Minimum Waiting Period

Waiting periods are imposed as per the Interprovincial Agreement on Eligibility and Portability for insured persons moving into the Northwest Territories from other jurisdictions, generally until the first day of the third month, or until the first day of the thirteenth month in some cases.

4.2 Coverage During Temporary Absences In Canada

The Interprovincial Agreement on Eligibility and Portability and the Northwest Territories Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the Northwest Territories for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the Northwest Territories for work, vacation, secondments etc. When an individual is approved as being temporarily absent from the Northwest Territories, the full costs for insured services are paid for all services received in other jurisdictions.

The Northwest Territories participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The Northwest Territories Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada. Individuals are granted coverage for up to one year if they are outside the country for any reason.

As per section 11. (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. Reimbursement is determined by applying the Northwest Territories rate for the same service.

4.4 Prior Approval Requirement

With respect to the requirement to obtain approval before receiving elective services in other provinces, territories and outside the country, the NWT requires prior approval if coverage is to be considered for these services. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Assistance Supplementary Health Benefit Program ensures that economic barriers are reduced for all Northwest Territories residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Accessibility of beds has not been a problem in the Northwest Territories. If such a case arises, the resident is transported to another facility where appropriate beds exist. As of March 31, 2001, hospitals and health centres in the NWT faced some short-term staffing difficulties that had negative impacts on functions. However, through the use of medical travel arrangements, access to services was maintained.

The Northwest Territories recognizes that our facilities do not have sufficient capacity to offer an extensive range of medical, surgical, rehabilitative and diagnostic services. The Medical Travel Assistance Program is in place to ensure that residents are able to access the required services at facilities where available.

Measures taken in 2000-2001 to improve access to insured hospital services include the expansion of the telehealth program. The expansion originally planned for the 2000-2001 fiscal year was not fully completed as suitable equipment was not available. However, during the reporting period a number of steps were taken to ensure that installation of equipment and the upgrading of the three existing WestNet sites (Inuvik, Fort Smith and Yellowknife) would be completed in 2001-2002.

5.3 Access to Insured Physician and Dental-Surgical Services

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories.

The Medical Travel Assistance Program provides access to physicians for residents and the telehealth program has provided an expansion of specialist services to residents in isolated communities.

5.4 Physician Compensation

The *Medical Care Act* and the Medical Care Regulations are used in the Northwest Territories to govern payments to physicians. The NWT uses two models: fee-for-service and employee contracts, to compensate physicians. In 2000, the majority of fee-for-service family physicians opted out of fee-for-service and agreed to a contractual arrangement with the Northwest Territories.

Fee-for-service physician compensation is determined by negotiations between the Northwest Territories Medical Association and the Department of Health and Social Services. The Director of Medical Insurance and his or

her designates negotiate on behalf of the Department and the Northwest Territories Medical Association chooses a negotiation team from within their membership.

The Government of the Northwest Territories and the Northwest Territories Medical Association have negotiated an agreement, subsequently signed into law, as Regulations of the *Medical Care Act*. These regulations covered the period starting April 1997 through March 31, 2000. The current Agreement runs to March 31, 2002.

5.5 Payments to Hospitals

Payments are made to hospitals based on contribution agreements between the Boards of Management and the Department of Health and Social Services. Amounts allocated in the agreements are based upon the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Act* and the *Financial Administration Act*. No amendments were implemented in 2000-2001. A global budget is used to fund hospitals in the Northwest Territories.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents. For fiscal 2000-2001 these documents included the following:

- 2000 Budget Address
- 2000-2001 Main Estimates and
- 1999-2000 Public Accounts.
- Departmental Business Plans for the Department of Finance and the Department of Health and Social Services.

The Estimates noted above represent the financial plan of the GNWT and is presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Nursing home-level care is supported by the Hospital Insurance Plan and provided in designated beds in facilities located in Inuvik, Yellowknife, Hay River, and Fort Smith.

Health and Social Services Boards are core funded by the Department of Health and Social Services to provide long-term care services to residents of the Northwest Territories. These services include long-term care facilities, group homes, supported living options and home care.

Long-term care facilities provide complex medical and personal care. Group homes and supported living options provide services to the severe mentally and physically disabled population. Home care provides services to people of all ages, based upon an assessed need, to allow them to continue to live independently in the community, in their own home for as long as possible, to prevent or delay institutionalization.

When appropriate services are not available in the NWT, clients are accommodated in facilities in southern Canada.

Provision of Additional Materials

In the NWT, the health and social services system has been extensively reviewed over the past few years by the Legislative Assembly's Special Committee on Health and Social Services (1993) and the Med-Emerg Review (1998). During the reporting period, the report from the Minister's Forum on Health and Social Services was received. The Minister's Forum urged the Government to take action on issues around board structure and financing, but without providing specific suggestions. Copies of the Report and other materials produced by

the NWT Department of Health and Social Services can be found at www.hlthss.gov.nt.ca

In addition, NWT legislation, regulations and other documents such as Main Estimates can be found at [www.gov.nt.ca]. During the reporting period, no audit of the health insurance plan was conducted.

Nunavut

Overview

Nunavut was formed as a territory on April 1, 1999. The Territory covers one-fifth of Canada's total landmass. There are 26 communities situated across three time zones. According to recent statistics, the population of Nunavut is 27,692. Inuit make up the majority at about 85 percent of the total residents. There is a small French-speaking population of about four to six percent residing on Baffin Island, predominantly in the capital city of Iqaluit. As well, Nunavut has a highly transient workforce, particularly skilled labourers and seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories as Nunavut statutes pursuant to the *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness for the Government of Nunavut as set out in the objectives of the Bathurst Mandate. The Bathurst Mandate outlines the Government's agenda to achieve healthy communities, simplicity and unity, self-reliance, and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimanituqangit, in program policy development, service design and delivery, is an expectation placed on all departments.

Health service delivery in Nunavut is based on a primary health care model. There is a local health centre in each of the 25 communities, as well as one regional hospital in Iqaluit. The primary health care providers are nurse practitioners. There are 12 physicians located at the hospital and three physicians in private practice (two in Iqaluit and one in Pond Inlet). Nunavut relies heavily on the Northern Medical Unit of the University of Manitoba, Ottawa Health Services Network Inc., and the Stanton Regional Hospital in Yellowknife for a majority of its physician and specialist services.

The management and delivery of health services in Nunavut is now integrated into the overall operations of the Department of Health and Social Services. The former boards (Baffin, Kitikmeot and Keewatin) were dissolved on March 31, 2000. Former board staff are now employees of the Department. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The territorial budget for health care and social services in 2000-2001 was $115.9 million, plus an additional $4.3 million for capital. Only the Department of Education has a higher budget.

In 2000-2001, telehealth services were developed in five communities. In March 2001 the Department was advised that its proposal under the Canada Health Info-structure Partnerships Program (CHIPP) was approved to enable expansion of telehealth services to an additional ten communities over the next two years.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Approximately one fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and a limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent outside the Territory. Plans to build a new regional hospital in Iqaluit and new regional health facilities in Rankin Inlet and Cambridge Bay in the next three years will enable Nunavut to build internal capacity and enhance the range of services provided.

High rates of respiratory diseases such as tuberculosis continue. There is an acute shortage of nurses, despite aggressive national and international recruitment and retention activities.

Health promotion and prevention activities are high on the Department's list of service priorities. These include strategies to reduce tobacco use, public education for healthy lifestyle choices and the importance of traditional foods.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration* Act (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) enables the establishment of hospital and other health services.

Through the *Dissolution Act* (Nunavut, 1999) the three former Health and Social Services Boards of Baffin, Kitikmeot and Keewatin were dissolved. Their operations were integrated into the Department of Health and Social Services on April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

1.2 Reporting Relationship

A Director of Medical Care appointed under the *Medical Care Act* is responsible for administering the Territory's medical care insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. The Department plans to table its first reports for 1999-2000 and 2000-2001 in the Legislative Assembly in February 2002. Our annual submissions to the *Canada Health Act Annual Report* serve as the basis for these reports under the *Medical Care Act*.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit for the fiscal year ending March 31, 2001 was being conducted as of September 2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the authority of the *Hospital and Social Services Administration Act* and Regulations, sections 2 to 4. No amendments were made to Legislation or Regulations in 2000-2001.

In 2000-2001, insured hospital services were delivered in 26 facilities throughout Nunavut, including one general hospital located in Iqaluit and 25 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut that provides a range of in- and out-patient hospital services as defined by the *Canada Health Act*. Community health centres provide public health, emergency-room services and some overnight services (observations). There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre.

The Department is responsible for authorizing, licensing, inspecting and supervising all health and social service facilities in Nunavut.

Insured in-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations prescribed by a physician and administered in hospital;
- routine surgical supplies;
- use of operating room, case-room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available;
- psychiatric and psychological services provided under an approved program;
- services rendered by persons paid by the hospital; and
- services rendered by an approved detoxification centre.

Out-patient services include:

- laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
- hospital services in connection with most minor medical and surgical procedures;
- physiotherapy, occupational therapy, audiology and speech therapy services in an out-patient facility or in an approved hospital; and
- psychiatric and psychology services provided under an approved hospital program.

The Department of Health and Social Services makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Nunavut Financial Management Board. No new insured hospital services were added in 2000-2001.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1) and the Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to the Legislation or Regulations in 2000-2001.

Medical doctors are the only practitioners permitted to deliver insured physician services in Nunavut. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practise in Nunavut. The Government of the Northwest Territories' Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 15 physicians in Nunavut (three in private practice and twelve at the Baffin Regional Hospital in Iqaluit) providing services to Nunavummiut. Visiting specialists, general practitioners and locums also provide insured physician services through arrangements made by each of the Department's three regions.

Physicians can collect fees other than those listed in the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked on the first day of the following month after a letter to that effect is delivered to the Director. No physicians provided written notice of this election in 2000-2001.

Insured physician services means all medically required services rendered by medical practitioners. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction.

The addition or deletion of insured physician services requires territorial approval. There were no additions or deletions in 2000-2001.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) and are provided billing numbers for the purpose of billing the Plan for the provision of

insured dental services. In 2000-2001, three oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to dental-surgical procedures scheduled in the Regulations that require the unique capabilities of a hospital for their performance, for example, orthognathic surgery.

The addition of new surgical-dental services to the list of insured services requires territorial approval. No new services were added in 2000-2001.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut* Act, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include:

- yearly physicals;
- cosmetic surgery;
- services that are considered experimental;
- prescription drugs;
- physical examinations done at the request of a third party;
- optometric services;
- dental services other than specific procedures related to jaw injury or disease;
- the services of chiropractors, naturopaths, podiatrists, osteopaths, and acupuncture treatments; and
- physiotherapy, speech therapy, and psychology services received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include

- hospital charges above the standard ward rate for private or semi-private accommodation;
- services that are not medically required, such as cosmetic surgery;
- services that are considered experimental;
- ambulance charges (except inter-hospital transfers);
- dental services, other than specific procedures related to jaw injury or disease; and
- alcohol and drug rehabilitation, unless previously approved.

The Baffin Regional Hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see 4.2 under Portability). Queries or complaints are handled on individual bases with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Interprovincial/Territorial Agreement on Eligibility and Portability, and internal guidelines.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins on the first day of the third month after arrival, but first-day coverage is provided under a number of circumstances, e.g., newborns whose mothers or fathers are eligible for coverage. Permanent residents, including landed immigrants, returning Canadians, repatriated Canadians, returning permanent residents, and non-Canadians who have been issued employment visas for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Forces, Royal Canadian Mounted Police and inmates of a federal penitentiary are not eligible for coverage. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Interprovincial/ Territorial Agreement on Eligibility and Portability, persons temporarily absent from their home province or territory and who are not establishing residency in Nunavut remain covered by their own provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

These include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut will be going to a staggered renewal process once a new health claims system is put into place next fiscal year. There are no premiums. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. Non-residents need a valid health care card from their home province or territory in order to access insured health services.

As of March 31, 2001, there were approximately 26,887 residents registered with the Nunavut Health Care Plan. Nunavut's population statistics as published by Statistics Canada include a number of "temporary residents" who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis, consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Interprovincial/ Territorial Agreement on Eligibility and Portability, the waiting period for coverage for individuals moving within Canada is three months or the first day of the third month following the establishment of residency in a new province or territory, or the first day of the third month when a person who has been temporarily absent from his or her home province decides to take up permanent residence in Nunavut.

4.2 Coverage During Temporary Absences In Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*,

sections 5(d) and 28(1)(j)(o) provide authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents, and the terms and conditions of payment. No legislative or regulatory changes were made in 2000-2001 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continued coverage. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences of up to one year for work, vacation or other reasons are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months on receipt of a written request from the insured person.

The provisions regarding coverage during temporary absences within Canada fully comply with the terms and conditions of the Interprovincial/Territorial Agreement on Eligibility and Portability, as of January 1, 1998.

Nunavut participates in Physician and Hospital Reciprocal Billing, and agreements are in place with other provinces and territories (Ontario, Manitoba, Alberta and the Northwest Territories).

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents who receive insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents who receive insured services outside the Territory. Payment is made to the host province at the rates established by that province.

The sum of $17,221,307 (of which $3,381,922 was for 1999-2000) was paid to out-of-territory hospitals for the fiscal year 2000-2001.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3) prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o) provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care. No changes were made to these rates in 2000-2001.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made either to the insured person or the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barriers posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients, if required, in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital in Iqaluit, is the only acute care facility in Nunavut. The hospital has 25 beds, but due to a shortages of nurses in 2000-2001, an average of 16 beds was available for acute, rehabilitation and chronic care services. The hospital has a staff of 101, including 12 physicians and 33 nurses. The facility provides in-patient, out-patient, and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services include an ambulatory care/ out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, gastrointestinal bleeding and hypertension treatment. Surgical services include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill, Winnipeg, Edmonton and Yellowknife, to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency services are provided by all 25 health centres located in the communities.

Although nurses and other health professionals were not at the desired levels of staffing, all basic services were provided in 2000-2001. Nunavut is seeking to increase resources in all areas.

5.3 Access to Insured Physician and Dental-Surgical Services

In addition to the medical travel assistance and telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. Patients are referred to other jurisdictions for services and equipment unavailable in Nunavut. In 2000-2001, Nunavut had 59 general/family practitioners, 55 physician specialists and 21 general and specialist dental practitioners.

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry, and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There are three fee-for-service physicians residing in Nunavut. Because these physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20 percent greater than the amounts set out in the schedule (*Medical Care Act*, section 4). The fees are negotiated between the NWT Medical Association and Nunavut's Department of Health and Social Services. The remaining physicians work on contract at a per diem rate or are paid a salary. Visiting specialists are paid on a per diem basis under the terms of their contracts.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 25 community health centres is part of the Department's budget for regional operations. No payments are made directly to the hospital or to the community health centres.

6.0 Recognition Given to Federal Transfers

Recognition will be given this year when the Director of Medical Care presents the 1999-2000 and 2000-2001 annual reports to the Minister. These reports will be tabled in the Legislative Assembly in early 2002.

7.0 Extended Health Care Services

A home care program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency, and supports family members and community involvement to enable individuals to remain safely in their own homes. Services include basic housekeeping, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are provided between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut, that is, extensive chronic care services up to the point of acute care (levels 4 and 5) services. Acute care cases are transferred to the nearest hospital.

The use of telehealth services has been a significant step in improving access to hospital, medical and other health and social services. Pilot projects are underway in five communities. To date, telehealth has been used for mental health counselling, family visits, and pre- and post-natal visits. The long-term goal is to integrate telehealth into the primary care delivery system, to allow residents and health care providers greater access to a broader range of service options, and to use existing resources more effectively. Our approved Canada Health Infostructure Partnership Program (CHIPP) proposal will allow Nunavut to provide telehealth services to an additional ten communities over the next two years.

Annex A – Provincial and Territorial Health Care Insurance Plan Statistics

Introduction

The purpose of this Annex is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the Act.

The Annex contains statistical data on the cost and utilization of insured hospital, physician and surgical-dental services for each province and territory for the five consecutive fiscal years ending on March 31 of 1996-1997, 1997-1998, 1998-1999, 1999-2000 and 2000-2001.

New to this year's statistical annex are statistics on registered persons covered by the health care insurance plans, the number of opted-out and non-participating physicians of the health care insurance plans, and statistics on out-of-country physician services.

All information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, provincial/territorial governments were provided with a user's guide outlining what and how to provide the information. The user's guide was prepared in consultation with representatives in each province and territory.

Although efforts were made to capture data on a consistent basis, differences exist in the reporting of health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions should not be made.

The annex is organized in the same order as the provincial/territorial health care insurance plan descriptions. Quebec chose to submit selected statistics in a format different from the one requested.

Organization of the Information

Information for each province and territory is organized according to the eight subcategories described below. In some cases data were not yet available and estimates were provided. In other cases, no information was available or the requested statistic did not apply to the particular province or territory.

For a discussion on some of the data shown in these tables, please refer to Chapter 2 – Provincial and Territorial Health Care Insurance Plans in 2000-2001.

Registered Persons

Registered persons are the number of residents registered with the health care insurance plans of each province or territory.

In-Province/Territory Hospital Services

Statistics on the provision of insured hospital services within each jurisdiction to residents of the jurisdiction and to visitors from other provinces or territories are provided in fields 2 through 13.

Details include numbers of facilities by type of care provided; number of beds; number of separations; average length of stay; total payments in the province/territory per category of care; average cost per visit by type of care; and the number and payments to private for-profit facilities.

Out-of-Province/Territory Hospital Services (in Canada)

Out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada are shown in this subsection. The information reported includes the total number of claims paid for insured hospital services in other provinces or territories, total payments made, and the average payment level.

Out-of-Country Hospital Services

Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are of the same type as hospital services provided out-of-province or out-of-territory.

In-Province/Territory Surgical-Dental Services

The information in this subsection describes insured surgical-dental services provided in each province and territory. This includes the number of participating professionals (dentists, dental surgeons, and oral surgeons); the number of services provided; total payments made in the fiscal year; and the average payment per service.

In-Province/Territory Physician Services

Statistics in this subsection relate to the provision of insured physician services to residents in each province or territory as well as to visitors from other regions of Canada.

Details include the number of physicians participating in the provincial or territorial health insurance plan; the number of physicians opted-out or not participating in the plan; the number of insured services provided; the total payments made to physicians by category of physician and by category of service; and the average payment level per insured physician service.

Out-of-Province/Territory Physician Services (in Canada)

This subsection reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents. Statistics include the number of services paid, total payments made, and the average payment level per service.

Out-of-Country Physician Services

Physician services provided out-of-country represent a person's medical costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are the same as for physician services provided out-of-province or out-of-territory.

Newfoundland and Labrador

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	not available	635,835 [1]	622,744	618,118 [2]	616,944 [3]

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	33	33	33	33	32
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	33	33	33	33	32
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care	1,860	1,842	1,814	1,807	not available
b. chronic care	0	0	0	0	0
c. rehabilitative care	38	38	62	57	not available
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total staffed beds	1,898	1,880	1,876	1,864	not available
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care	1,860	1,842	1,814	1,807	not available
b. chronic care	0	0	0	0	0
c. rehabilitative care	38	38	62	57	not available
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total approved bed complement	1,898	1,880	1,876	1,864	not available

1 Data are as of December 31, 1997.

2 Data are as of March 1, 2000.

3 Data are as of April 11, 2001.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		68,766	67,385	68,729	66,828	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		108	54	227	272	not available
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care		0	0	0	0	0
f. alternative level of care		0	0	0	0	0
g. newborns		0	0	0	0	0
h. other		0	0	0	0	0
i. total separations		68,874	67,439	68,956	67,100	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		8.0	7.9	7.5	7.4	not available
b. chronic care		0.0	0.0	0.0	0.0	0.0
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		0.0	0.0	0.0	0.0	0.0
e. other		0.0	0.0	0.0	0.0	0.0
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		431,336,662 [4]	441,408,824 [4]	457,065,782 [4]	509,018,766 [4]	537,428,824 [4]
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total payments to facilities providing insured hospital services		431,336,662 [4]	441,408,824 [4]	457,065,782 [4]	509,018,766 [4]	537,428,824 [4]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		675.0 [5]	675.0 [5]	690.0 [5]	690.0 [5]	705.0 [5]
b. chronic care		0.0	0.0	0.0	0.0	0.0
c. rehabilitative care		0.0	0.0	0.0	0.0	0.0
d. other		0.0	0.0	0.0	0.0	0.0

[4] Operating costs only; does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.

[5] Insured Canadian resident rate.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	0	1	1	1	1
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total private for-profit health care facilities	0	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	0	not available	not available	not available	not available
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities	0	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	0	53,808	212,990	387,030	270,750
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total payments to private for-profit health care facilities	0	53,808	212,990	387,030	270,750

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	1,796	1,970	1,826	1,549	1,699
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	22,187	26,293	28,739	25,546	24,929
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	11,550,785	11,286,130	12,037,091	10,144,354	10,608,368
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	2,048,471	2,656,772	3,316,482	3,138,582	3,047,375
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	6,431.0	5,729.0	6,592.0	6,549.0	6,244.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	92.0	101.0	115.0	123.0	122.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	72	39	42	73	111
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	366	374	363	260	287
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	144,887	161,364	503,043	198,072	1,102,540
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	33,298	38,985	56,614	15,626	36,260
24. Average payment for out-of-country, in-patient insured hospital services.	($)	2,012.0	4,137.0	4,997.0	2,713.0	9,933.0
25. Average payment for out-of-country, out-patient insured hospital services.	($)	91.0	104.0	156.0	60.0	126.0

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	29	25	30	35	35
27. Number of insured surgical-dental services provided by participating dentists.	(#)	11,000	10,000	10,000	9,000	11,000
28. Total payments to dentists for insured surgical-dental services.	($)	335,000	309,000	374,000	354,000	389,000
29. Average payment per service for insured surgical-dental services.	($)	30.2	32.5	38.3	38.7	35.1

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: [6]	(#)					
a. general practitioners		not available	not available	not available	432 [7]	437 [7]
b. specialists		not available	not available	not available	480 [7]	485 [7]
c. other		not available	not available	not available	not applicable	not applicable
d. total		not available	not available	not available	912 [7]	922 [7]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

[6] Excludes inactive physicians.

[7] Total Salaried and Fee-for-service.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	2,783,000	2,623,000	2,471,000	2,489,000	2,340,000
b. specialists	2,206,000	2,407,000	2,440,000	2,443,000	2,318,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,989,000	5,030,000	4,911,000	4,932,000	4,657,000
34. Number of insured physician services provided, by category of service: (#)					
a. medical	3,257,000	3,195,000	3,107,000	3,104,000	2,878,000
b. surgical	447,000	487,000	487,000	468,000	433,000
c. diagnostic	1,285,000	1,348,000	1,317,000	1,361,000	1,346,000
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	4,989,000	5,030,000	4,911,000	4,932,000	4,657,000
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	44,392,000	40,956,000	41,521,000	42,429,000	43,251,000
b. specialists	61,611,000	67,314,000	71,640,000	72,780,000	73,239,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	106,003,000	108,270,000	113,161,000	115,209,000	116,490,000
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	72,500	71,987
b. surgical	not available	not available	not available	10,923	10,834
c. diagnostic	not available	not available	not available	31,786	33,670
d. other	not available	not available	not available	not applicable	not applicable
e. total	106,003,000	108,270,000	113,161,000	115,209,000	116,490,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	16.0	15.6	16.8	17.1	18.5
b. specialists	27.9	28.0	29.4	29.8	31.6
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	21.3	21.5	23.0	23.4	25.0
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. all services	21.3	21.5	23.0	23.4	25.0

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	155,000	163,000	171,000	161,000	173,000
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	3,920,000	4,346,000	4,241,000	4,327,000	4,562,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	25.4	26.6	24.8	28.4	26.4

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	3,000	4,000	4,000	4,000	6,000
43. Total payments for out-of-country insured physician services.	($)	76,000	94,000	65,000	107,000	424,000
44. Average payment per service for out-of-country insured physician services.	($)	23.5	22.4	17.3	19.6	70.2

Prince Edward Island

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st (#)	122,867	126,124	130,004	134,006	138,205

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care (#)					
a acute care	7	7	7	7	7
b chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f other	not applicable	not applicable	not applicable	not applicable	not applicable
g total facilities	7	7	7	7	7
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed (#)					
a acute care	470	470	470	470	470
b chronic care	57	57	57	57	57
c rehabilitative care	20	20	20	20	20
d out-patient diagnostic care	19	19	19	19	19
e other	not applicable	not applicable	not applicable	not applicable	not applicable
f total staffed beds	566	566	566	566	566
4. Approved bed complement for all facilities providing insured hospital services, by type of bed (#)					
a acute care	470	470	470	470	470
b chronic care	57	57	57	57	57
c rehabilitative care	20	20	20	20	20
d out-patient diagnostic care	19	19	19	19	19
e other	not applicable	not applicable	not applicable	not applicable	not applicable
f total approved bed complement	566	566	566	566	566

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5 Number of separations from all facilities providing insured hospital services, by type of care (#)					
a acute care	18,047	18,626	18,644	17,796	18,280
b chronic care	not available	not available	not available	not available	not available
c rehabilitative care	336	347	377	360	329
d out-patient diagnostic care	not available	not available	not available	not available	not available
e surgical day care (out-patient)	6,295	5,911	6,250	6,186	not available
f alternative level of care	not available	not available	not available	not available	267
g newborns	not available	not available	not available	not available	1,363
h other	not applicable	not applicable	not applicable	not applicable	not applicable
i total separations	24,678	24,884	25,271	24,342	20,239
6 Average length of in-patient stay in all facilities providing insured hospital services, by type of care (# of days)					
a acute care	8.2	8.1	7.9	8.4	8.2
b chronic care	not available	not available	not available	not available	not available
c rehabilitative care	18.0	19.0	19.0	18.0	20.0
d newborns	not available	not available	not available	not available	not available
e other	not applicable	not applicable	not applicable	not applicable	not applicable
7 Payments to facilities providing insured hospital services, by the facility's primary type of care ($)					
a acute care	95,100,000	94,800,000	101,600,000	104,000,000	106,774,200
b chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f other	not applicable	not applicable	not applicable	not applicable	not applicable
g total payments to facilities providing insured hospital services	95,100,000	94,800,000	101,600,000	104,000,000	106,774,200
8 Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care ($)					
a acute care	642.6	628.4	689.8	695.7	not available
b chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d other	not applicable	not applicable	not applicable	not applicable	not applicable

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In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	1,893	1,904	2,279	1,812	not available [1]
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	11,478	13,341	16,457	14,428	not available [1]
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	11,900,000	11,300,000	12,300,000	10,600,000	not available [1]
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	1,400,000	1,700,000	2,600,000	2,300,000	not available [1]
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	6,286.0	5,935.0	5,397.0	5,850.0	not available [1]
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	122.0	127.0	158.0	160.0	not available [1]

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	35	48	27	21	not available [1]
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	157	211	102	106	not available [1]
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	121,000	119,400	50,100	53,800	not available [1]
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	41,500	76,600	11,700	21,700	not available [1]
24. Average payment for out-of-country, in-patient insured hospital services.	($)	3,457.0	2,488.0	1,856.0	2,561.0	not available [1]
25. Average payment for out-of-country, out-patient insured hospital services.	($)	264.0	363.0	115.0	205.0	not available [1]

[1] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	1	1	2	2	2
27. Number of insured surgical-dental services provided by participating dentists.	(#)	418	411	400	276	145
28. Total payments to dentists for insured surgical-dental services.	($)	49,900	50,200	52,700	37,600	53,100
29. Average payment per service for insured surgical-dental services.	($)	119.0	[illegible]	132.0	214.0	366.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		92	97	98	99	101
b. specialists		80	75	72	74	75
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		172	172	170	173	176
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	838,527	834,740	869,320	848,816	861,112
b. specialists	386,714	394,912	422,483	415,130	409,917
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,225,241	1,229,652	1,291,803	1,263,946	1,271,029
34. Number of insured physician services provided, by category of service: (#)					
a. medical	132,979	141,594	158,836	154,930	152,796
b. surgical	139,338	138,667	146,186	144,947	143,940
c. diagnostic	114,397	114,651	117,461	115,253	113,181
d. other	838,527	834,740	869,320	848,816	861,112
e. total	1,225,241	1,229,652	1,291,803	1,263,946	1,271,029
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	14,400,000	14,800,000	15,000,000	15,700,000	15,800,000
b. specialists	15,300,000	15,600,000	16,200,000	17,100,000	17,200,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	29,700,000	30,400,000	31,200,000	32,800,000	33,000,000
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	5,600,000	5,900,000	6,200,000	6,600,000	6,500,000
b. surgical	8,000,000	8,000,000	8,300,000	8,800,000	8,900,000
c. diagnostic	1,700,000	1,700,000	1,700,000	1,700,000	1,800,000
d. other	not applicable	not applicable	not applicable	not applicable	15,800,000
e. total	29,700,000	30,400,000	31,200,000	32,800,000	33,000,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	17.0	18.0	17.0	18.0	18.0
b. specialists	40.0	40.0	38.0	41.0	42.0
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	24.0	25.0	24.0	26.0	26.0
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	42.0	42.0	39.0	43.0	43.0
b. surgical	57.0	58.0	57.0	61.0	62.0
c. diagnostic	15.0	15.0	15.0	15.0	15.0
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. all services	24.0	25.0	24.0	26.0	26.0

Out-of-Province/Territory Physician Services (in Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	57,904	58,667	56,192	56,084	not available [1]
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	2,650,000	2,780,000	3,090,000	3,080,000	not available [1]
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	46.0	47.0	55.0	55.0	not available [1]

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	907	1,242	807	666	not available [1]
43. Total payments for out-of-country insured physician services.	($)	35,805	52,874	25,495	38,274	not available [1]
44. Average payment per service for out-of-country insured physician services.	($)	39.0	42.0	31.0	57.0	not available [1]

[1] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

Nova Scotia

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	930,805	933,324	937,587	944,487	947,963

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	36	36	36	36	36
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities	36	36	36	36	36
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,375 [1]	3,226 [1]	3,233 [1]	3,135 [1]	3,044 [1]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds	3,375	3,226	3,233	3,135	3,044
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

[1] Includes rehabilitative care.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		109,722	108,536	106,954	104,509	94,745
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		897 [2]	944 [2]	855 [2]	792 [2]	800 [2]
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		77,432	86,014	89,046	93,700	96,832
f. alternative level of care		916	1,422	1,690	2,002	2,064
g. newborns		10,474	9,951	9,675	9,607	9,038
h. other		not available	not available	133	135	150
i. total separations		198,525 [3]	205,445 [3]	206,530 [3]	208,608 [3]	201,415 [3]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		7.7	8.2	7.9	8.3	8.6
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		36.7	45.6	44.8	45.0	48.6
d. newborns		3.5	3.7	3.7	3.7	3.8
e. other		not available	not available	124.8	159.4	147.1
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [4]	($)					
a. acute care		645,026,000	701,208,000	795,946,000	812,776,800	877,019,426
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		645,026,000	701,208,000	795,946,000	812,776,800	877,019,426
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		435.9	435.9	391.6	391.6	391.6
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

2 Type 4 level of care.

3 Excludes separations with alternative level of care days.

4 $'s are paid to acute care facilities/DHAs only.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	89.0 [5]	89.0 [5]	110.0 [5]	110.0 [5]	110.0 [5]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	3,249.1	3,413.1	3,853.9	3,896.2	4,354.3
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	1	1	1	1	1
b. private diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities	1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities	not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities	not available	not available	not available	not available	not available

5 Standard National Rate for Out-Patient Services.

Out-of-Province/Territory Hospital Services (In Canada)					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada). (#)	2,173	2,331	2,395	2,380	2,357
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada). (#)	24,521	29,165	29,927	30,078	32,174
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada). ($)	9,141,843	8,864,423	10,395,116	10,502,390	9,559,303
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada). ($)	2,506,490	3,038,860	3,770,060	3,771,435	4,083,677
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada). ($)	4,207.0	3,802.8	4,340.3	4,412.8	4,055.7
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada). ($)	102.2	104.2	126.0	125.4	126.9

Out-of-Country Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. (#)	not available	not available	not available	not available	not available
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. (#)	not available	not available	not available	not available	not available
22. Total payments for out-of-country, in-patient, insured hospital services. ($)	1,003,664	851,689	859,642	1,053,577	736,104
23. Total payments for out-of-country, out-patient, insured hospital services. ($)	not available	not available	not available	not available	not available
24. Average payment for out-of-country, in-patient insured hospital services. ($)	not available	not available	not available	not available	not available
25. Average payment for out-of-country, out-patient insured hospital services. ($)	not available	not available	not available	not available	not available

In-Province/Territory Surgical-Dental Services					
Insured Dental Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan. (#)	55	53	54	55	39
27. Number of insured surgical-dental services provided by participating dentists. (#)	14,525	15,549	16,909	17,525	6,853
28. Total payments to dentists for insured surgical-dental services. ($)	1,439,885	1,515,311	1,726,646	1,467,485	988,692
29. Average payment per service for insured surgical-dental services. ($)	99.1	97.5	102.1	83.7	144.3

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	not available	not available	not available	829	741 [6]
b. specialists	not available	not available	not available	1,095	1,016 [6]
c. other	0	0	0	0	0
d. total	1,826	1,836	1,853	1,924	1,757 [6]
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0

[6] Figures adjusted to show only those physicians within each subcategory.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	not available	4,443,772	4,334,359	4,619,083	4,571,239
b. specialists	not available	1,854,669	1,794,146	1,606,842	1,576,479
c. other	not available	0	0	0	0
d. total	6,298,935	6,298,441	6,128,505	6,225,925	6,147,718
34. Number of insured physician services provided, by category of service: (#)					
a. medical	not available	5,980,487	5,809,644	5,908,054	4,637,320 [7]
b. surgical	not available	317,854	320,861	317,871	331,316 [7]
c. diagnostic	not available	1,545,203	1,544,529	1,514,011	604,275 [7]
d. other	not available	0	0	0	574,778 [7]
e. total	6,854,885	7,843,544	7,675,034	7,739,936	6,147,689 [7]
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	94,476,324	91,782,118	91,620,190	104,587,110	105,480,167
b. specialists	108,424,409	115,725,195	118,656,216	112,250,617	114,919,756
c. other	0	0	0	0	0
d. total	202,900,733	207,507,313	210,276,406	216,837,727	220,399,923
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	142,110,171 [7]
b. surgical	not available	not available	not available	not available	52,737,469 [7]
c. diagnostic	not available	not available	not available	not available	19,583,421 [7]
d. other	not available	not available	not available	not available	5,967,370 [7]
e. total	267,449,785	296,138,155	317,320,281	350,091,235	220,398,370 [7]
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	not available	20.7	21.1	22.6	23.1
b. specialists	not available	62.4	66.1	69.9	72.9
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	32.2	32.9	34.3	34.8	35.9
38. Average payment per service for insured physician services, by category of service: [7] ($)					
a. medical	not available	not available	not available	not available	30.6
b. surgical	not available	not available	not available	not available	183.7
c. diagnostic	not available	not available	not available	not available	32.4
d. other	not available	not available	not available	not available	10.4
e. all services	39.0	37.8	41.3	45.2	35.9

[7] Fee-for-service only.

Out-of-Province/Territory Physician Services (in Canada) [1]						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	not available	not available	not available	not available	180,299
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	not available	not available	not available	not available	4,766,189
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	not available	not available	not available	not available	26.4

Out-of-Country Physician Services [1]						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	2,541
43. Total payments for out-of-country insured physician services.	($)	not available	not available	not available	not available	98,461
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	38.7

[1] Payments totalling $123,448 are not included in questions 39 - 44 as the distribution between out-of-province/territory and out-of-country for amount paid is unknown. As well, the number of services are not known.

New Brunswick

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	747,173	742,218	735,510	739,336	738,598

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	31	31	31	31	31
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	32	32	32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,036	3,036	3,036	3,036	3,036
b. chronic care	397	397	397	397	397
c. rehabilitative care	20	20	20	20	20
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total approved bed complement	3,453	3,453	3,453	3,453	3,453

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	110,549	110,865	109,542	108,353	102,465
b. chronic care	2,423	2,260	2,398	2,281	1,887
c. rehabilitative care	406	457	411	444	465
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	45,175	44,597	42,962	46,287	46,345
f. alternative level of care	231	246	307	308	342
g. newborns	8,347	8,050	7,939	7,778	7,455
h. other	0	0	0	0	0
i. total separations	167,131	160,495	163,559	165,451	158,959
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	6.3	6.6	6.8	6.8	7.1
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	41.9	39.1	47.3	41.3	41.2
d. newborns	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services	596,141,800	629,964,593	639,764,216	674,487,768	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities	not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities	not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities	not available	not available	not available	not available	not available

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	3,827 pts / 28,086 days	3,566 pts / 24,993 days	3,768 pts / 24,915 days	3,900 pts / 25,655 days	4,130 pts / 26,572 days
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	31,229	31,684	36,081	32,796	35,834
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	24,836,405	21,515,090	21,863,730	22,473,974	21,561,907
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	3,108,218	3,295,272	4,374,860	4,235,429	4,702,219
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	884.3	860.8	877.5	876.0	811.5
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	99.5	104.0	121.3	129.1	131.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	231 pts / 1,110 days	190 pts / 788 days	145 pts / 661 days	212 pts / 1,691 days	166 pts / 1,096 days
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	1,318	881	395	524	639
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	1,106,445	385,548	150,403	487,760	458,759
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	159,197	101,585	85,443	105,783	180,712
24. Average payment for out-of-country, in-patient insured hospital services.	($)	996.8	489.3	227.5	288.4	418.6
25. Average payment for out-of-country, out-patient insured hospital services.	($)	120.8	115.3	216.3	201.9	282.8

In-Province/Territory Surgical-Dental Services					
Insured Dental Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan. (#)	12	14	17	12	16
27. Number of insured surgical-dental services provided by participating dentists. (#)	602	632	790	751	1,004
28. Total payments to dentists for insured surgical-dental services. ($)	96,683	119,524	132,577	136,491	189,777
29. Average payment per service for insured surgical-dental services. ($)	160.6	189.1	167.8	181.7	189.0

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	575	581	619	629	645
b. specialists	678	682	709	721	710
c. other	not available	not available	not available	not available	not available
d. total	1,253	1,263	1,328	1,350	1,355
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	3,626,061	3,625,877	3,692,566	3,721,782	3,668,781
b. specialists	2,423,736	2,479,186	2,551,663	2,612,744	1,568,927 [1]
c. other	not available	not available	not available	not available	not available
d. total	6,049,797	6,105,063	6,244,229	6,334,526	5,237,708
34. Number of insured physician services provided, by category of service: (#)					
a. medical	684,943	686,896	729,803	739,911	726,947
b. surgical	805,335	827,458	828,626	852,725	839,980
c. diagnostic	933,458 [2]	964,832 [2]	993,234 [2]	1,020,108 [2]	not available
d. other	3,626,061	3,625,877	3,692,566	3,721,782	3,668,781
e. total	6,049,797	6,105,063	6,244,229	6,334,526	5,237,708
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	73,575,982	74,575,504	77,851,628	77,958,130	78,139,070
b. specialists	96,165,584	100,834,441	104,752,866	111,554,173	88,908,789 [1]
c. other	not available	not available	not available	not available	not available
d. total	169,741,566	175,409,945	182,604,494	189,512,303	167,047,859
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	36,116,218	37,548,393	40,384,442	41,795,791	41,068,744
b. surgical	44,697,549	46,574,724	46,871,179	48,732,272	47,840,045
c. diagnostic	15,351,817 [2]	16,711,324 [2]	17,497,245 [2]	21,026,109 [2]	not available
d. other	73,575,982 [3]	74,575,504 [3]	77,851,628 [3]	77,958,130 [3]	78,139,070 [3]
e. total	169,741,566	175,409,945	182,604,494	189,512,302	167,047,859
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	20.3	20.6	21.1	20.9	21.3
b. specialists	39.7	40.7	41.1	42.7	56.7
c. other	not available	not available	not available	not available	not available
d. all physicians	28.1	28.7	29.2	29.9	31.9
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	52.7	54.7	55.3	56.5	56.3
b. surgical	55.5	56.3	56.6	57.1	57.0
c. diagnostic	16.4 [2]	17.3 [2]	17.6 [2]	20.6 [2]	not available
d. other	20.3 [3]	20.6 [3]	21.1 [3]	20.9 [3]	21.3 [3]
e. all services	28.1	28.7	29.2	29.9	31.9

1 Radiology data are incomplete for fiscal year 2000-2001.

2 Radiology only.

3 Includes General Practitioners.

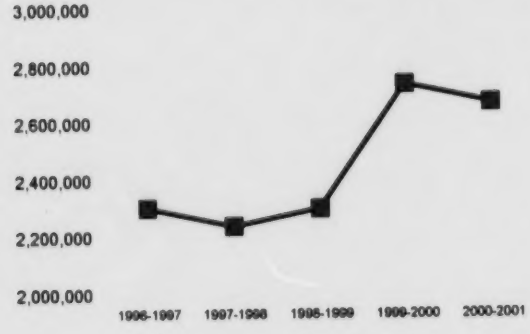
Out-of-Province/Territory Physician Services (In Canada)					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada). (#)	132,873	153,230	140,375	137,950	160,119
40. Total payments for out-of-province/territory insured physician services (in Canada). ($)	4,665,617	6,186,476	5,684,969	6,050,729	7,697,923
41. Average payment per service for out-of-province/territory insured physician services (in Canada). ($)	35.1	40.4	40.5	43.9	48.1

Out-of-Country Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services. (#)	6,675	7,283	3,835	4,554	4,200
43. Total payments for out-of-country insured physician services. ($)	321,754	366,996	223,066	356,128	362,709
44. Average payment per service for out-of-country insured physician services. ($)	48.2	50.4	58.2	78.2	86.4

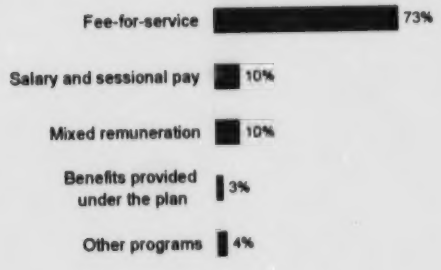
Quebec[1]

Medical Services	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
	(in thousands of dollars)				
Health insurance plan	2,209,354	2,145,535	2,203,461	2,634,945	2,562,034
Fee-for-service	1,870,783	1,789,854	1,820,968	2,173,993	1,957,201
Specialists	1,131,647	1,081,637	1,090,532	1,257,148	1,105,463
General practitioners	672,547	636,807	657,450	841,128	774,215
Commission of Health and Occupational Safety	43,461	47,533	49,935	54,249	52,822
Payments made to insured persons	13,992	14,790	14,135	12,473	15,826
Health professionals outside Quebec	9,136	9,087	8,916	8,995	8,875
Salary and sessional pay	291,039	294,761	300,447	289,919	267,658
Sessional and lump-sum fees	192,028	200,312	212,843	208,119	183,217
Salary and fixed fees	91,833	87,852	81,226	75,520	78,043
Commission of Health and Occupational Safety	7,178	6,597	6,378	6,280	6,398
Mixed remuneration	-	-	-	72,856	258,949
Health insurance plan	-	-	-	72,234	256,732
Commission of Health and Occupational Safety	-	-	-	622	2,217
Benefits provided under the plan	47,532	60,920	82,046	98,177	78,226
Special measures	34,516	49,010	56,735	57,699	48,229
Professional liability insurance	13,016	11,910	25,311	40,478	29,997
Other programs	94,673	93,967	97,230	102,809	109,755
Remuneration to medical residents	93,351	92,670	95,964	101,247	108,100
Other	1,322	1,297	1,266	1,562	1,655
Total	**2,304,027**	**2,239,502**	**2,300,691**	**2,737,754**	**2,671,789**

Changes in Costs



Distribution of Costs for 2000-2001



[1] Quebec chose to not submit information in the type or in the manner requested by Health Canada. The table and charts have been reproduced directly from Quebec's submission to Health Canada.

Ontario

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	10.9 M [1]	11.2 M [1]	11.3 M [1]	11.4 M [1]	11.7 M [1]

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		not available [2]	179	157	154	150
b. chronic care		not available [2]	20	22	12	11
c. rehabilitative care		not available [2]	6	5	4	4
d. out-patient diagnostic care		not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
e. surgical day care (out-patient)		not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
f. other		not available [2]	4	4	3	3
g. total facilities		not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		26,267	24,505	23,872	24,254	25,008
b. chronic care		8,678	8,149	7,787	7,505	7,455
c. rehabilitative care		1,875	1,815	1,822	1,975	2,137
d. out-patient diagnostic care		not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. other		not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
f. total staffed beds		not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
b. chronic care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
c. rehabilitative care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
d. out-patient diagnostic care		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
e. other		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
f. total approved bed complement		not available [7]	not available [7]	not available [7]	not available [7]	not available [7]

1 M = Millions.

2 Historical data no longer available.

3 Ontario does not have facilities in these categories. These types of facilities are privately owned and any insured services provided are covered by the province.

4 Day surgery only reports cases and the stretchers are not reported whereas acute, chronic and rehabilitative units report beds and have separations.

5 Total is not available since some of the items in the list are not available.

6 Details for other types of beds are not kept separately, they are included as part of the acute, chronic and rehabilitation beds reporting.

7 Not available - there is no central repository for this information.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	1,074,967	1,041,004	1,131,333	1,007,464	1,004,042
b. chronic care	17,321	18,426	17,165	18,943	19,777
c. rehabilitative care	17,399	18,513	188,865	20,837	20,236
d. out-patient diagnostic care	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
e. surgical day care (out-patient)	814,595	879,826	896,833	943,045	983,916
f. alternative level of care	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
g. newborns	140,746	137,114	134,505	134,136	130,062
h. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
i. total separations	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	6.5 [9]	6.4 [9]	6.5 [9]	6.6 [9]	7.0 [9]
b. chronic care	162.1 [9]	140.8 [9]	129.1 [9]	128.9 [9]	118.1 [9]
c. rehabilitative care	32.3	32.3	30.3	29.9	26.3
d. newborns	2.9	2.9	2.8	2.9	3.0
e. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
b. chronic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
c. rehabilitative care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
d. out-patient diagnostic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
e. surgical day care (out-patient)	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
f. other	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
g. total payments to facilities providing insured hospital services	7.4 B [12]	6.7 B [12]	7.1 B [12]	7.5 B [12]	8.0 B [12]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	626.0	654.0	691.0	761.0	not available [13]
b. chronic care	253.0	266.0	274.0	287.0	not available [13]
c. rehabilitative care	363.0	369.0	385.0	436.0	not available [13]
d. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]

5 Total is not available since some of the items in the list are not available.

8 Not available - the data is not collected by these classifications -e.g. alternative level of care is included with acute separations.

9 Data has been revised - acute length of stay previously omitted acute mental health patients - chronic data was reviewed and revised to match internal reporting.

10 Other types of care are not segregated.

11 a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed.

b) Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.

12 B = Billion.

13 Data not available at time of report production.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. out-patient diagnostic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
e. surgical day care (out-patient)		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
f. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total insured hospital services provided at private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total payments to private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]

[14] Not available - the reliability of the data is questionable and the results of the calculations are questionable and are not supportable or reportable.

a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of activity.

b) Separating by facility type gives a small sample size and significantly understates the amount of activity related to chronic and rehabilitative outpatients.

c) Mergers and amalgamations during this period also contribute variability to the figures particularly when viewed by main activity.

[15] Not available - the data is not collected within a single system in the ministry.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	6,494	8,004	8,431	9,031	9,540
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	80,263	102,504	104,398	155,648	161,882
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	27.9 M	36.2 M	32.8 M	41.3 M	39.9 M
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	8.3 M	10.7 M	13.3 M	18.7 M	22.0 M
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	4,296.0	4,523.0	3,890.0	4,573.0	4,182.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	103.0	104.0	127.0	120.0	136.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	30,688	26,211	24,141	20,657	20,503
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	included in #20	included in #20	included in #20	included in #20	included in #20
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	31.6 M	25.0 M	21.4 M	17.0 M	18.8 M
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	included in #22	included in #22	included in #22	included in #22	included in #22
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,030.0	954.0	886.0	823.0	918.0
25. Average payment for out-of-country, out-patient insured hospital services.	($)	included in #24	included in #24	included in #24	included in #24	included in #24

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	367	366	350	350 [16]	357
27. Number of insured surgical-dental services provided by participating dentists.	(#)	67,156	69,163	70,658	69,400	71,660
28. Total payments to dentists for insured surgical-dental services.	($)	7.8 M	7.9 M	7.9 M	8.1 M	8.2 M
29. Average payment per service for insured surgical-dental services.	($)	116.2	114.2	111.8	116.7	115.2

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		10,475 [17]	10,319	10,221	10,227	10,281
b. specialists		9,825	9,944	9,994	10,284	10,392
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		20,300	20,263	20,215	20,511	20,673
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		33	29	26	25	25
b. specialists		221	209	196	188	177
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		254	238	222	213	202
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
b. specialists		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
c. other		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
d. total		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]

16 Number of participating dentists was 350, but over 700 are registered on the Corporate Provider Database.

17 a) Source for all insured physician services data: Ontario Statistical Reporting System (OSRS) April 1996-March 2000.
b) Numbers in the Annex are number of physicians who bill through the fee-for-service (FFS) system. The Annex numbers are derived from the Ontario Statistical Reporting System. Not all physicians who are registered bill under the FFS system. Number of physician services do not include laboratory services. Also, obstetrical care is included under medical services.
c) Physician services include assistant and anaesthetist time based units, and the diagnostic portion includes both the professional and technical components counted separately.
d) Numbers as of end of March of each fiscal year.

18 All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

19 Ontario has no non-participating physicians, only opted-out physicians who are reported under item #31.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	82.0 M	83.6 M	80.4 M	79.6 M	79.7 M
b. specialists	85.9 M	90.8 M	89.9 M	91.4 M	93.6 M
c. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total	167.9 M	174.4 M	170.3 M	171.0 M	173.3 M
34. Number of insured physician services provided, by category of service: (#)					
a. medical	84.1 M	85.3 M	84.2 M	84.1 M	82.9 M
b. surgical	21.4 M	22.2 M	21.6 M	22.0 M	22.3 M
c. diagnostic	62.4 M	66.8 M	64.4 M	64.8 M	68.1 M
d. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. total	167.9 M	174.3 M	170.2 M	170.9 M	173.3 M
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	1,688.3 M	1,722.7 M	1,676.9 M	1,725.2 M	1,734.1 M
b. specialists	2,443.5 M	2,618.6 M	2,587.2 M	2,699.2 M	2,824.3 M
c. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total	4131.8 M	4341.3 M	4264.1 M	4424.4 M	4,558.4 M
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	2,593.9 M	2,664.5 M	2,605.6 M	2,678.6 M	2,699.8 M
b. surgical	586.2 M	616.0 M	608.5 M	633.8 M	670.8 M
c. diagnostic	951.7 M	1,060.8 M	1,050.1 M	1,112.0 M	1,187.8 M
d. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. total	4,131.8 M	4,341.3 M	4,264.2 M	4,424.4 M	4,558.4 M
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	20.6	20.6	20.9	21.7	21.8
b. specialists	28.5	28.8	28.8	29.5	30.2
c. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. all physicians	24.6	24.9	25.1	25.9	26.3
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	30.8	31.2	30.9	31.8	32.6
b. surgical	27.5	27.7	28.2	28.8	30.1
c. diagnostic	15.2	15.9	16.3	17.2	17.5
d. other	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. all services	24.6	24.9	25.1	25.9	26.3

[18] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	399,005	428,329	433,396	455,136	433,463
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	12.9 M	12.8 M	13.3 M	14.0 M	14.3 M
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	32.0	30.0	31.0	31.0	33.0

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	266,856	228,379	207,736	184,107	179,679
43. Total payments for out-of-country insured physician services.	($)	8.1 M	7.5 M	7.0 M	11.6 M	15.5 M
44. Average payment per service for out-of-country insured physician services.	($)	30.0	33.0	34.0	63.0	86.0

Manitoba

Registered Persons [1]					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	1,144,643	1,146,331	1,142,465	1,144,424	1,149,904

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	95	95	95	95	95
b. chronic care	4 [2]	4 [2]	4 [2]	4 [2]	3 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities	99	99	99	99	98
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: [3] (#)					
a. acute care	4,628	4,559	4,436	4,394	4,406
b. chronic care	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: [3] (#)					
a. acute care	4,628	4,559	4,439	4,394	4,406
b. chronic care	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total approved bed complement	5,187	4,951	4,841	4,796	4,791

1 The population data is based on records of residents registered with Manitoba Health as at June 1.

2 Includes both chronic care and rehabilitative care.

3 The number of beds that are set up as of March 31 for patient accommodation by a hospital.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	139,463	136,931	136,499	132,650	127,903
b. chronic care	1,640	1,746	1,757	1,876	1,905
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	99,571	107,418	111,931	115,136	116,305
f. alternative level of care	not available	not available	not available	not available	not available
g. newborns	15,838	14,784	14,814	14,807	14,403
h. other	not available	not available	not available	not available	not available
i. total separations	256,512	260,879	265,001	264,469	260,516
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	9.3	9.3	9.5	9.7	9.9
b. chronic care	103.6 [2]	118.0 [2]	74.3 [2]	69.0 [2]	78.4 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. newborns	3.6	3.7	3.9	3.5	3.5
e. other	not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available	not available	not available	not available	953,834,797
b. chronic care	not available	not available	not available	not available	65,153,895
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services	not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

[2] Includes both chronic care and rehabilitative care.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	3,174	3,419	3,307	2,571	3,037
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	24,779	28,422	28,007	21,570	29,217
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	12,506,685	14,156,175	11,292,528	8,655,520	12,152,757
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	2,321,046	2,947,701	3,451,891	2,694,973	4,089,018
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	3,940.4	4,140.4	3,414.7	3,366.6	4,001.6
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	93.7	103.7	123.3	124.9	139.9

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	530	614	588	565	567
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	5,810	6,331	5,782	6,053	6,335
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	854,120	991,294	1,058,815	1,028,127	1,065,302
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	611,162	658,890	690,877	905,479	2,435,560
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,611.6	1,614.5	1,800.7	1,819.7	1,878.8
25. Average payment for out-of-country, out-patient insured hospital services.	($)	105.2	104.1	119.5	149.6	384.5

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	65	94	102	105	101
27. Number of insured surgical-dental services provided by participating dentists.	(#)	2,681	2,953	2,925	3,318	3,256
28. Total payments to dentists for insured surgical-dental services.	($)	496,505	539,940	589,378	590,125	660,870
29. Average payment per service for insured surgical-dental services.	($)	185.2	182.8	201.5	177.9	203.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		970	935	900	915	948
b. specialists		972	931	938	939	not available
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		1,882	1,866	1,838	1,854	not available
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	5,726,851	5,741,645	5,859,568	5,931,022	6,211,011
b. specialists	6,712,187	7,281,386	7,698,155	8,147,749	8,741,628
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	12,439,038	13,023,031	13,557,723	14,078,771	14,952,639
34. Number of insured physician services provided, by category of service: (#)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	99,387,716	99,489,900	103,068,422	114,868,502	132,200,004
b. specialists	146,956,655	153,336,002	165,946,999	178,359,474	199,231,274
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	246,344,371	252,825,902	269,015,421	293,227,976	331,431,278
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	307,890,771	351,821,602	376,500,221	416,902,176	467,886,678
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	17.4	17.3	17.6	19.4	21.3
b. specialists	21.9	21.1	21.6	21.9	22.8
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	19.8	19.4	19.8	20.8	22.2
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Out-of-Province/Territory Physician Services (In Canada)					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada). (#)	222,601	217,733	206,521	183,497	192,272
40. Total payments for out-of-province/territory insured physician services (in Canada). ($)	6,627,296	6,245,462	6,121,559	5,568,205	6,148,444
41. Average payment per service for out-of-province/territory insured physician services (in Canada). ($)	28.2	28.7	29.6	30.3	32.0

Out-of-Country Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services. (#)	6,993	7,222	6,587	7,116	6,763
43. Total payments for out-of-country insured physician services. ($)	466,323	518,102	519,928	520,712	500,757
44. Average payment per service for out-of-country insured physician services. ($)	66.7	71.7	78.9	73.2	74.0

Saskatchewan

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	1,027,551	1,020,351	1,031,933	1,041,256	1,021,762

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	75	73	71	71	68
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	76	74	72	72	69
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,282 [1]	3,117	3,078	2,944	2,802
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not available	142	142	142	142
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other [2]	not available	722	735	718	670
f. total staffed beds	not available	3,981	3,955	3,804	3,614
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

1 Count of acute care staffed beds for 1996-1997 is an estimate.

2 "Other" staffed beds include long term care beds and beds in psychiatric units of hospitals.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	148,740	146,537	143,604	133,768	131,305 [3]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	1,401	1,338	1,058	927	977 [3]
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient) [4]	45,224	50,090	53,890	55,426	55,527 [3]
f. alternative level of care	not available	not available	not available	not available	not available
g. newborns	13,418	12,882	12,819	12,597	11,993 [3]
h. other [5]	4,106	3,988	3,309	4,065	4,393 [3]
i. total separations [6]	212,889	214,835	214,680	206,783	204,195 [3]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	5.7	5.7	5.8	5.6	5.7 [3]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	32.4	30.9	30.5	34.7	31.9 [3]
d. newborns	3.7	3.7	3.5	3.7	3.6 [3]
e. other [5]	16.3	16.5	15.4	15.8	15.9 [3]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	522,036,613	584,582,800	565,682,800	619,538,151	680,326,248
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	34,822,774	35,115,992	35,437,299	36,824,546	38,249,010
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services	556,859,387	619,698,792	601,120,099	656,362,697	718,575,258
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

[3] Separations and average length of stay for 2000-2001 are based on preliminary data.

[4] Surgical day care (out-patient) cases shown are cases involving day procedures that appear on the Canadian Institute for Health Information's 1991 list of operative procedures.

[5] "Other" separations are separations from psychiatric units in acute care hospitals.

[6] Total separations exclude long term care separations.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	0	0	0	0	0
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total private for-profit health care facilities	0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	0	0	0	0	0
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities	0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	0	0	0	0	0
b. private diagnostic imaging facilities	0	0	0	0	0
c. Total payments to private for-profit health care facilities	0	0	0	0	0

Out-of-Province/Territory Hospital Services (In Canada)					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada). (#)	4,788	4,868	4,688	5,019	4,587
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada). (#)	35,493	38,279	41,375	44,327	45,195
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada). ($)	21,051,931	23,988,792	18,973,762	19,911,192	20,203,300
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada). ($)	3,836,058	4,161,896	3,472,464	3,504,388	6,046,600
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada). ($)	4,396.8	4,927.9	4,047.3	3,967.2	4,404.5
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada). ($)	108.1	108.7	83.9	79.1	133.8

Out-of-Country Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. (#)	337	317	273	382	286
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. (#)	1,574	1,695	1,252	1,201	1,355
22. Total payments for out-of-country, in-patient, insured hospital services. ($)	288,000	710,626	1,193,449	2,484,961	1,022,000
23. Total payments for out-of-country, out-patient, insured hospital services. ($)	132,500	228,968	151,558	348,379	377,600
24. Average payment for out-of-country, in-patient insured hospital services. ($)	854.6	2,241.7	4,371.6	6,505.1	3,573.4
25. Average payment for out-of-country, out-patient insured hospital services. ($)	84.2	135.1	121.1	290.1	278.7

In-Province/Territory Surgical-Dental Services					
Insured Dental Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan. (#)	126	119	113	97	92
27. Number of insured surgical-dental services provided by participating dentists. (#)	18,600	18,700	18,500	18,100	19,900
28. Total payments to dentists for insured surgical-dental services. ($)	1,291,000	1,287,000	1,272,000	1,309,000	1,404,700
29. Average payment per service for insured surgical-dental services. ($)	69.4	68.8	68.8	72.3	70.6

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	860	865	907	940	1,016
b. specialists	583	592	595	610	593
c. other	0	0	0	0	0
d. total	1,443	1,457	1,502	1,550	1,609
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	6,868,246	6,595,192	6,742,712	6,785,673	6,873,539
b. specialists	3,121,981	3,068,576	3,127,345	3,163,046	3,250,953
c. other	0	0	0	0	0
d. total	9,990,227	9,663,768	9,870,057	9,948,719	10,124,492
34. Number of insured physician services provided, by category of service: [7] (#)					
a. medical	6,229,799 [8]	5,989,580 [8]	6,048,849 [8]	6,028,070 [8]	6,071,567 [8]
b. surgical	739,787 [9]	728,803 [9]	735,770 [9]	723,626 [9]	787,655 [9]
c. diagnostic	2,404,982 [10]	2,323,818 [10]	2,345,180 [10]	2,312,606 [10]	2,288,038 [10]
d. other	615,659 [11]	621,567 [11]	740,258 [11]	884,417 [11]	977,232 [11]
e. total	9,990,227	9,663,768	9,870,057	9,948,719	10,124,492
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	122,511,451	119,002,444	128,784,792	133.042,948	134,989,267
b. specialists	118,134,845	117,666,741	122,465,930	125,735,201	129,470,569
c. other	0	0	0	0	0
d. total	240,646,296	236,669,185	251,250,722	258,778,149	264,459,836
36. Total payments to physicians for insured physician services, by category of service: [7] ($)					
a. medical	140,292,403 [8]	137,691,861 [8]	143,548,623 [8]	148,848,496 [8]	151,152,270 [8]
b. surgical	52,990,753 [9]	51,536,110 [9]	51,255,592 [9]	50,843,890 [9]	51,681,286 [9]
c. diagnostic	38,430,693 [10]	37,944,132 [10]	40,473,208 [10]	41,503,336 [10]	43,216,810 [10]
d. other	8,932,447 [11]	9,497,081 [11]	15,973,299 [11]	17,582,427 [11]	18,409,471 [11]
e. total	240,646,296	236,669,184	251,250,722	258,778,149	264,459,837
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	17.8	18.0	19.1	19.6	19.6
b. specialists	37.8	38.3	39.2	39.8	39.8
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	24.1	24.5	25.5	26.0	26.1
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	22.5 [8]	23.0 [8]	23.7 [8]	24.7 [8]	24.9 [8]
b. surgical	71.6 [9]	70.7 [9]	69.7 [9]	70.3 [9]	65.6 [9]
c. diagnostic	16.0 [10]	16.3 [10]	17.3 [10]	17.9 [10]	18.9 [10]
d. other	14.5 [11]	15.3 [11]	21.6 [11]	19.9 [11]	18.8 [11]
e. all services	24.1	24.5	25.5	26.0	26.1

[7] Fee-for-service.

[8] Includes visits, hospital care, psychotherapy.

[9] Includes surgeries, surgical assistance, obstetrics, anaesthesia.

[10] Includes x-rays, laboratory, diagnostics.

[11] Includes surcharges, premiums, on-call.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	318,200	361,000	374,900	392,400	425,800
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	9,286,800	10,501,400	10,897,500	12,237,200	13,767,600
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.2	29.1	29.1	31.2	32.3

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	519,400	644,300	658,400	1,186,900	722,400
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

Alberta

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	2,786,526	2,847,538	2,912,925	2,957,045	3,007,582

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	102 [2]	102 [2]	102 [2]	102 [2]	102 [2]
b. chronic care	104	104	104	104	105
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	0	0	0	3	3
g. total facilities	207	207	207	210	211
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	6,176	6,305	6,404	6,275	6,284
b. chronic care	6,179	6,179	6,179	6,179	6,358
c. rehabilitative care	240	240	240	240	240
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds	12,595	12,724	12,823	12,694	12,882
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	9,788	9,788	9,788	9,788	9,788
b. chronic care	6,114	6,114	6,114	6,114	6,164
c. rehabilitative care	240	240	240	240	240
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	16,142	16,142	16,142	16,142	16,192

1 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

2 Section 2 - acute care facilities was revised for the years 1996/1997 to 1999/2000 to include one extra facility.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		not available	not available	not available	not available	not available
h. other		not available	not available	not available	not available	not available
i. total separations		332,665	334,869	346,092	346,316	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		not applicable	not applicable	not applicable	not applicable	not applicable
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total private for-profit health care facilities	not available	not available	not available	not available	not available
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities	not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities	not available	not available	not available	not available	not available

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	4,565	4,656	4,714	4,820	4,535
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	55,477	56,408	57,574	59,443	59,815
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	16,065,099	14,699,049	13,269,781	13,632,730	12,647,870
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	5,170,997	5,287,271	6,706,065	6,920,702	6,955,005
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	3,519.2	3,157.0	2,815.0	2,828.4	2,788.9
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	93.2	93.7	116.5	116.4	116.3

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. [3]	(#)	4,686 [4]	3,843 [4]	4,005 [4]	5,215 [4]	4,151
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. [3]	(#)	4,696 [4]	4,668 [4]	3,777 [4]	5,097 [4]	3,945
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	437,393 [4]	363,087 [4]	356,747 [4]	483,648 [4]	374,005
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	351,698 [4]	349,217 [4]	275,687 [4]	364,087 [4]	298,725
24. Average payment for out-of-country, in-patient insured hospital services.	($)	93.3 [4]	94.5 [4]	89.1 [4]	92.7 [4]	90.1
25. Average payment for out-of-country, out-patient insured hospital services.	($)	74.9 [4]	74.8 [4]	73.0 [4]	71.4 [4]	75.7

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

[3] Data are the total number of service units paid for out-of-country, insured hospital services.

[4] Sections 20 to 25 were revised from previous editions of the *Canada Health Act Annual Report* due to an error in designating services and payments between in-patients and out-patients for fiscal years 1996-1997 to 1999-2000.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
26. Number of dentists participating in the health insurance plan.	(#)	241	230	232	250	232
27. Number of insured surgical-dental services provided by participating dentists.	(#)	9,063	10,648	11,920	14,292	14,708
28. Total payments to dentists for insured surgical-dental services.	($)	1,571,065	1,691,797	1,853,322	2,092,003	2,116,386
29. Average payment per service for insured surgical-dental services.	($)	173.3	158.9	155.5	146.4	143.9

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		2,395	2,365	2,464	2,545	2,659
b. specialists		1,833	1,903	1,978	2,096	2,197
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		4,228	4,268	4,442	4,641	4,856
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	1
c. other		0	0	0	0	0
d. total		0	0	0	0	1

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	13,947,484	14,377,354	14,974,783	15,543,092	15,914,666
b. specialists	9,291,690	9,844,887	10,392,632	10,798,883	11,319,078
c. other	0	0	0	0	0
d. total	23,239,174	24,222,241	25,367,415	26,341,975	27,233,744
34. Number of insured physician services provided, by category of service: (#)					
a. medical	17,875,863 [5]	18,411,601 [5]	19,119,550 [5]	19,829,029 [5]	20,328,498 [5]
b. surgical	1,117,537 [5]	1,155,663 [5]	1,211,712 [5]	1,238,043 [5]	1,316,312 [5]
c. diagnostic	4,245,774 [5]	4,654,977 [5]	5,036,153 [5]	5,274,903 [5]	5,588,934 [5]
d. other	0	0	0	0	0
e. total	23,239,174 [5]	24,222,241 [5]	25,367,415 [5]	26,341,975 [5]	27,233,744 [5]
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	346,643,288	357,611,870	383,842,634	410,502,506	430,681,658
b. specialists	399,772,398	427,232,284	464,270,463	493,040,446	528,392,197
c. other	0	0	0	0	0
d. total	746,415,686	784,844,154	848,113,097	903,542,952	959,073,855
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	498,946,649 [5]	514,667,078 [5]	549,507,274 [5]	586,587,852 [5]	618,596,110 [5]
b. surgical	120,802,134 [5]	125,595,149 [5]	133,916,239 [5]	140,067,988 [5]	150,223,933 [5]
c. diagnostic	126,666,903 [5]	144,581,927 [5]	164,689,584 [5]	176,887,112 [5]	190,253,812 [5]
d. other	0	0	0	0	0
e. total	746,415,686 [5]	784,844,154 [5]	848,113,097 [5]	903,542,952 [5]	959,073,855 [5]
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	24.9	24.9	25.6	26.4	27.1
b. specialists	43.0	43.4	44.7	45.7	46.7
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	32.1	32.4	33.4	34.3	35.2
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	27.9 [5]	28.0 [5]	28.7 [5]	29.6 [5]	30.4 [5]
b. surgical	108.1 [5]	108.7 [5]	110.5 [5]	113.1 [5]	114.1 [5]
c. diagnostic	29.8 [5]	31.1 [5]	32.7 [5]	33.5 [5]	34.0 [5]
d. other	0.0	0.0	0.0	0.0	0.0
e. all services	32.1 [5]	32.4 [5]	33.4 [5]	34.3 [5]	35.2 [5]

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

[5] Sections 34, 36 and 38 were revised to reflect services and payments based on type of service rather than specialty of the physician. This data was revised for the years ended March 31, 1996/1997 to 1999/2000.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	355,985	348,480	359,653	380,635	418,587
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	10,412,565	10,092,203	9,983,110	11,397,620	12,436,188
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.3	29.0	27.8	29.9	29.7

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
42. Number of services paid for out-of-country, insured physician services.	(#)	34,221	30,649	25,192	21,989	20,891
43. Total payments for out-of-country insured physician services.	($)	1,128,302	972,645	862,852	871,292	907,010
44. Average payment per service for out-of-country insured physician services.	($)	33.0	31.7	34.3	39.6	43.4

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

British Columbia

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	3,920,273	3,951,853	3,924,490	3,943,991	4,022,789

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	93	93	94	94	94
b. chronic care	17	17	17	17	18
c. rehabilitative care	2	3	3	3	3
d. out-patient diagnostic care	25	25	25	25	25
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	1	1	0	0	0
g. total facilities	138	139	139	139	140
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	8,871	8,822	8,834	8,533	8,994
b. chronic care	8,641	8,628	8,018	8,733	9,102
c. rehabilitative care	193	242	242	468	474
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	17,705	17,692	17,094	17,734	18,570

Estimates and projections have been made where there is incomplete data.

There is some instability in reporting due to regionalization and changes in reporting for health authorities.

Figures shown may differ from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database due to varying definitions.

Some health authorities use a non specific category (i.e. other) for statistics. Most often this is included in the acute care category.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care		345,523	367,465	376,369	374,246	378,427
b. chronic care		7,805	9,072	9,016	7,132	7,502
c. rehabilitative care		2,612	2,445	2,497	2,466	2,753
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		295,117	289,951	274,295	293,530	288,705
f. alternative level of care		5,365	3,591	3,060	3,798	3,882
g. newborns		36,462	40,968	41,085	40,566	39,947
h. other		not applicable	not applicable	not applicable	not applicable	not applicable
i. total separations		692,884	713,492	706,322	721,738	721,216
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care		5.6	5.9	5.8	6.0	6.0
b. chronic care		351.0	325.7	211.5	340.6	379.0
c. rehabilitative care		33.5	32.2	28.9	28.5	26.9
d. newborns		2.9	6.7	2.2	2.4	2.6
e. other		30.8	33.7	29.0	29.3	28.5
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

Estimates and projections have been made where there is incomplete data.

There is some instability in reporting due to regionalization and changes in reporting for health authorities.

Figures shown may differ from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database due to varying definitions.

Some health authorities use a non specific category (i.e. other) for statistics. Most often this is included in the acute care category.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	1	1
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total private for-profit health care facilities	not available	not available	not available	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities	not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities	not available	not available	not available	not available	not available
b. private diagnostic imaging facilities	not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities	not available	not available	not available	not available	not available

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	7,225	7,383	7,994	7,231	8,113
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	62,604	68,146	73,807	70,070	83,765
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	37,483,341	35,898,630	35,830,522	34,477,406	35,882,521
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	6,145,727	7,441,321	9,075,191	9,585,916	9,149,496
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	5,188.0	4,862.0	4,482.0	4,768.0	4,422.8
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	98.0	109.0	123.0	137.0	109.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	2,946	2,888	2,793	2,494	2,097
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	340	431	435	324	720
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	2,251,755	3,073,456	3,492,437	5,375,289	6,463,676
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	77,502	109,347	100,863	65,137	134,789
24. Average payment for out-of-country, in-patient insured hospital services.	($)	764.0	1,064.0	1,250.0	2,155.0	3,082.3
25. Average payment for out-of-country, out-patient insured hospital services.	($)	228.0	254.0	232.0	201.0	187.2

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	284	289	280	265	283
27. Number of insured surgical-dental services provided by participating dentists.	(#)	53,130	53,163	51,096	54,507	55,820
28. Total payments to dentists for insured surgical-dental services.	($)	5,663,597	5,818,127	5,474,563	5,854,368	5,718,859
29. Average payment per service for insured surgical-dental services.	($)	106.6	109.4	107.1	107.4	102.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		4,154	4,248	4,269	4,276	4,360
b. specialists		3,116	3,181	3,232	3,269	3,298
c. other		0	0	0	0	0
d. total		7,270	7,429	7,501	7,545	7,658
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		5	3	4	4	3
b. specialists		13	11	13	10	5
c. other		0	0	0	0	0
d. total		18	14	17	14	8
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		1	1	1	1	1
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		1	1	1	1	1

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	22,197,196	22,378,959	21,903,525	22,875,620	23,051,810
b. specialists	28,828,096	29,424,394	29,860,276	32,697,836	34,551,897
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	51,025,292	51,803,353	51,763,801	55,573,456	57,603,707
34. Number of insured physician services provided, by category of service: (#)					
a. medical	23,535,944 [1]	24,309,601 [1]	24,012,366 [1]	25,065,926 [1]	25,201,483 [1]
b. surgical	5,601,151 [2]	4,209,195 [2]	4,163,434 [2]	4,426,656 [2]	4,417,069 [2]
c. diagnostic	21,888,197 [3]	23,294,557 [3]	23,588,001 [3]	26,080,874 [3]	27,985,155 [3]
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	51,025,292	51,813,353	51,763,801	55,573,456	57,603,707
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: [4] ($)					
a. general practitioners	613,317,385	614,713,789	626,992,277	654,305,224	663,325,757
b. specialists	817,739,525	831,174,498	845,235,143	928,642,083	965,611,051
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,431,056,910	1,445,888,287	1,472,227,420	1,582,947,307	1,628,936,808
36. Total payments to physicians for insured physician services, by category of service: [5] ($)					
a. medical	834,731,808	850,453,217	874,004,742	920,552,743	936,095,517
b. surgical	230,651,787	231,507,497	229,196,329	250,267,000	252,827,989
c. diagnostic	365,673,314	363,927,573	369,026,348	412,127,564	440,013,302
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,431,056,909	1,445,888,287	1,472,227,419	1,582,947,307	1,628,936,808
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	27.6	27.4	28.6	28.6	27.8
b. specialists	28.3	28.2	28.3	28.4	28.0
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	28.0	27.9	28.4	28.5	28.3
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	35.5	35.0	36.4	36.7	37.1
b. surgical	41.2	55.0	55.0	56.5	57.2
c. diagnostic	16.7	15.6	15.6	15.8	15.7
d. other	0.0	0.0	0.0	0.0	0.0
e. all services	28.0	27.9	28.4	28.5	28.3

1 Medical services consist of the following services: regional examinations, consultations, complete examinations, counselling, home visits, emergency visits, institutional visits, dialysis/transfusions, general services and therapeutic radiation (service codes 1 through 8, 22 through 28, 30, and 46 through 48).

2 Surgical services consist of the following services: anaesthesia, cardiovascular, obstetrics minor and non-minor surgeries (service codes 40 through 45).

3 Diagnostic services consist of the following services: diagnostic ophthamology, diagnostic radiology, diagnostic ultrasound, nuclear medicine, pathology, pulmonary function, electro-diagnosis, and procedural cardiology (service codes 89 through 98).

4 Expenditure includes paid amount, Northern and Isolation Allowance, premiums, and exclude tray fees.

5 Paid services consist of MSP fee-for-services provided between April 1, 2000 and March 31, 2001, paid to September 30, 2001.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	477,236	461,571	438,186	446,232	not available
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	13,844,944	13,849,906	13,495,893	14,134,689	not available
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.0	30.0	30.8	31.7	not available

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	73,297	66,361	68,707
43. Total payments for out-of-country insured physician services.	($)	not available	not available	3,504,870	3,336,415	3,947,293
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	47.8	50.3	57.5

Yukon

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	33,984	33,557	31,925	31,255	31,133

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	13 [1]	13 [1]	13 [1]	13 [1]	13 [1]
g. total facilities	15	15	15	15	15
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	70	59	59	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total staffed beds	79	68	68	70	70
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	70	59	59	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total approved bed complement	79	68	68	70	70

[1] Includes health centres and one health station.

[2] Day surgery beds.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	3,481	3,283	3,117	2,967	3,021
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	1,646	1,524	1,606	1,624	1,619
f. alternative level of care	0	0	0	0	0
g. newborns	452	437	392	374	363
h. other	0 [1]	0 [1]	0 [1]	0 [1]	0 [1]
i. total separations	5,579	5,244	5,115	4,965	5,003
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	4.5	4.0	4.5	4.7	4.7
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. newborns	3.0	3.0	2.9	3.0	3.1
e. other	not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	18,567,847	18,836,846	19,023,617	19,587,158	20,350,026
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	0	0	0	0	0
f. other	4,692,893 [1]	4,722,168 [1]	4,796,107 [1]	5,502,144 [1]	5,483,948 [1]
g. total payments to facilities providing insured hospital services	23,260,740	23,559,014	23,819,724	25,089,302	25,833,974
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	505.0	505.0	694.5	694.5	694.5
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not available	not available	not available	not available	not available

[1] Includes health centres and one health station.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		89.0	89.0	110.0	110.0	110.0
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		292.0	292.0	400.0	400.0	400.0
f. other		not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		311.1	362.7	349.7	337.2	335.5
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

[1] Includes health centres and one health station.

Out-of-Province/Territory Hospital Services (In Canada) [3]						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	712	732	769	735	698
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	5,621	6,109	6,637	7,025	6,690
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	4,751,127	4,434,174	4,196,661	4,683,562	4,220,525
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	584,070	645,165	826,425	920,769	857,580
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	6,673.0	6,058.0	5,457.0	6,372.0	6,047.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	104.0	106.0	125.0	131.0	128.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	11	14	13	11	8
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	67	42	53	67	54
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	62,847	34,445	45,440	22,125	20,597
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	32,462	5,502	7,354	7,080	8,368
24. Average payment for out-of-country, in-patient insured hospital services.	($)	5,713.0	2,460.0	3,495.0	2,011.0	2,575.0
25. Average payment for out-of-country, out-patient insured hospital services.	($)	485.0	131.0	139.0	102.0	156.0

[3] Claims for out of Province/Territory in Canada are still being received. Provinces have 12 months to submit their claims.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)	12	10	12	9	11
27. Number of insured surgical-dental services provided by participating dentists.	(#)	309	203	297	214	222
28. Total payments to dentists for insured surgical-dental services.	($)	75,331	50,840	64,397	59,458	50,876
29. Average payment per service for insured surgical-dental services.	($)	243.8	250.4	217.2	277.8	229.2

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		48	52	40	41	43
b. specialists		4	4	4	5	6
c. other		0	0	0	0	0
d. total		52	56	44	46	49
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33 Number of insured physician services provided, by type of physician (fee-for-service) (#)					
a general practitioners	161,680	164,544	151,743	153,542	164,497
b specialists	12,522	10,885	14,170	11,704	14,789
c other	0	0	0	0	0
d total	174,202	175,429	165,913	165,246	179,286
34 Number of insured physician services provided, by category of service (#)					
a medical	125,230	127,479	120,830	123,333	131,685
b surgical	26,775	25,425	23,110	22,092	25,670
c diagnostic	22,197	22,525	21,972	19,822	18,978
d other	0	0	0	0	0
e total	174,202	175,429	165,912	165,247	176,333
35 Total payments to (fee-for-service) physicians for insured physician services, by type of physician ($)					
a general practitioners	5,198,864	5,335,775	5,058,606	5,248,704	5,803,619
b specialists	1,076,028	1,184,312	1,321,577	1,189,271	1,263,380
c other	0	0	0	0	0
d total	6,274,892	6,520,087	6,380,183	6,437,975	7,066,999
36 Total payments to physicians for insured physician services, by category of service ($)					
a medical	5,040,362	5,182,278	5,026,530	5,144,453	5,729,729
b surgical	918,797	995,148	1,005,170	978,628	1,028,529
c diagnostic	315,733	342,661	348,483	314,893	308,741
d other	0	0	0	0	0
e total	6,274,892	6,520,087	6,380,183	6,437,974	7,066,999
37 Average payment per service for insured (fee-for-service) physician services, by type of physician ($)					
a general practitioners	32.2	32.4	33.3	34.2	35.3
b specialists	85.9	108.8	93.3	101.6	85.4
c other	0.0	0.0	0.0	0.0	0.0
d all physicians	36.0	37.2	38.5	39.0	39.4
38 Average payment per service for insured physician services, by category of service ($)					
a medical	40.2	40.7	41.6	41.7	43.5
b surgical	34.3	39.1	43.5	44.3	40.1
c diagnostic	14.2	15.2	15.9	15.9	16.3
d other	0.0	0.0	0.0	0.0	0.0
e all services	36.0	37.2	38.5	39.0	40.1

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	33,313	28,656	29,834	31,020	36,828
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	1,180,306	1,183,519	1,207,371	1,404,195	1,642,495
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	35.4	41.3	40.5	45.3	44.6

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

In-Province/Territory Physician Services [4]					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
45. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	not available	not available	not available	not available	not available
b. specialists	not available	not available	not available	not available	not available
c. all physicians	not available	not available	not available	not available	not available
46. Number of insured services provided, by category of physicians (fee-for-service): (#)					
a. general practitioners	23,759	27,583	30,391	27,757	21,028
b. specialists	11,411	11,848	10,443	11,332	5,254
c. all physicians	35,170	39,431	40,834	39,089	26,282
47. Number of insured services provided, by category services (#)					
a. medical services	29,629	33,975	33,007	31,609	19,865
b. surgical services	2,134	1,842	4,483	5,141	4,208
c. diagnostic services	3,407	3,614	3,344	2,339	2,209
d. all insured physician services	35,170	39,431	40,834	39,089	26,282
48. Total payment of (fee-for-service) physicians for insured services by category of physicians: (#)					
a. general practitioners	815,233	983,271	994,636	907,848	756,866
b. specialists	924,791	756,719	681,869	727,972	695,927
c. all physicians	1,740,024	1,739,990	1,676,505	1,635,820	1,452,793
49. Total payment to physicians for insured services, by category of (#)					
a. medical services	1,415,810	1,542,518	1,477,892	1,436,115	1,159,117
b. surgical services	232,831	112,736	121,755	132,349	208,679
c. diagnostic services	91,383	84,736	76,857	67,356	84,997
d. all insured physician services	1,740,024	1,739,990	1,676,504	1,635,820	1,452,793
50. Average payment for insured (fee-for-service) physicians services by category of physicians: ($)					
a. general practitioners	34.3	35.7	32.7	32.7	36.0
b. specialists	81.0	63.9	65.3	64.2	132.5
c. all physicians	49.5	44.1	41.1	41.9	55.3
51. Average payment for insured physician services by category of ($)					
a. medical services	47.8	45.4	44.8	45.4	58.4
b. surgical services	109.1	61.2	27.2	25.7	49.6
c. diagnostic services	26.8	23.5	23.0	28.8	38.5
d. all insured physician services	49.5	44.1	41.1	41.9	55.3

[4] Visiting Specialists, Locum Doctors and Member Reimbursements.

Northwest Territories

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)				41,000	41,673

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care				4 hospitals	4 hospitals
b. chronic care				not available [1]	not available [1]
c. rehabilitative care				not available [1]	not available [1]
d. out-patient diagnostic care				not available [1]	not available [1]
e. surgical day care (out-patient)				not available [1]	not available [1]
f. other				20	28
g. total facilities				32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total staffed beds				212	220
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total approved bed complement				212	220

[1] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				7,907	7,185
d. out-patient diagnostic care				not available	not available
e. surgical day care (out-patient)				2,748	2,438
f. alternative level of care				not available	not available
g. newborns				472	717
h. other				59,253	64,995
i. total separations				70,380	75,335
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				13.2	10.6
d. newborns				2.9	3.0
e. other				4.8	4.3
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				1,205,469	1,129,741
d. out-patient diagnostic care				not available	not available
e. surgical day care (out-patient)				1,099,200	975,200
f. other				34,548,885	33,823,823
g. total payments to facilities providing insured hospital services				36,853,554	35,928,763
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				1,479.6	1,625.7
d. other				1,354.7	1,357.7

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In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				110.0	109.8
d. out-patient diagnostic care				not available	not available
e. surgical day care (out-patient)				400.0	400.0
f. other				109.1	108.6
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				152.5	157.2
d. other				570.6	510.6
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total private for-profit health care facilities				0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total insured hospital services provided at private for-profit health care facilities				0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total payments to private for-profit health care facilities				0	0

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)				1,063	930
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)				7,798	7,999
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)				7,092,119	5,254,269
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)				1,150,303	1,361,059
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)				6,671.8	5,649.8
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)				147.5	170.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)				6	5
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)				12	15
22. Total payments for out-of-country, in-patient, insured hospital services.	($)				10,190	2,908
23. Total payments for out-of-country, out-patient, insured hospital services.	($)				2,270	1,459
24. Average payment for out-of-country, in-patient insured hospital services.	($)				1,698.4	581.5
25. Average payment for out-of-country, out-patient insured hospital services.	($)				189.2	97.3

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

In-Province/Territory Surgical-Dental Services					
Insured Dental Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan. (#)				not available	not available
27. Number of insured surgical-dental services provided by participating dentists. (#)				not available	not available
28. Total payments to dentists for insured surgical-dental services. ($)				not available	not available
29. Average payment per service for insured surgical-dental services. ($)				not available	not available

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners				35 [2]	29 [2]
b. specialists				18 [2]	18 [2]
c. other				106 [3]	151 [3]
d. total				159 [4]	198 [4]
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners				0	0
b. specialists				0	0
c. other				0	0
d. total				0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners				0	0
b. specialists				0	0
c. other				0	0
d. total				0	0

2 Southam Medical Database, Canadian Institute for Health Information.

3 This is an estimate of the number of locum physicians.

4 Total is based on number of names.

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In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners				134,396	81,777
b. specialists				9,432	5,355
c. other				7,203	0
d. total				151,031	87,132
34. Number of insured physician services provided, by category of service: (#)					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				212,997	199,277
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners				5,225,870	3,380,039
b. specialists				645,959	584,280
c. other				347,425	0
d. total				6,219,254	3,964,319
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				9,315,675	8,468,518
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners				38.9	41.3
b. specialists				68.5	109.1
c. other				48.2	not available
d. all physicians				41.2	45.5
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. all services				43.7	42.5

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Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)				36,002	35,301
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)				1,931,528	1,908,213
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)				53.7	54.1

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)				212	176
43. Total payments for out-of-country insured physician services.	($)				18,197	13,296
44. Average payment per service for out-of-country insured physician services.	($)				85.8	75.5

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Nunavut

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)				not available	26,829

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care				1 Hospital	1 Hospital
b. chronic care				25 Health Centres	25 Health Centres
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. surgical day care (out-patient)				not available	not available
f. other				not available	not available
g. total facilities				not available	not available
				not available	not available
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total staffed beds				not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total approved bed complement				not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	(#)					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. alternative level of care					not available	not available
g. newborns					not available	not available
h. other					not available	not available
i. total separations					not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	(# of days)					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. newborns					not available	not available
e. other					not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	($)					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. other					not available	not available
g. total payments to facilities providing insured hospital services					not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	($)					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. other					not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. surgical day care (out-patient)				not available	not available
f. other				not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care: ($)					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. other				not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: (#)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total private for-profit health care facilities				0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care: (#)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total insured hospital services provided at private for-profit health care facilities				0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care: ($)					
a. private surgical facilities				0	0
b. private diagnostic imaging facilities				0	0
c. Total payments to private for-profit health care facilities				0	0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14 Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada)	(#)				1,842	1,549
15 Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada)	(#)				9,656	8,682
16 Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada)	($)				8,546,013	7,612,791
17 Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada)	($)				1,470,018	1,352,594
18 Average payment for out-of-province/territory, in-patient insured hospital services (In Canada)	($)				4,639.0	4,915.0
19 Average payment for out-of-province/territory, out-patient insured hospital services (In Canada)	($)				152.0	156.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20 Total number of claims paid for out-of-country, in-patient, insured hospital services	(#)				14	0
21 Total number of claims paid for out-of-country, out-patient, insured hospital services	(#)				5	1
22 Total payments for out-of-country, in-patient, insured hospital services	($)				12,010	0
23 Total payments for out-of-country, out-patient, insured hospital services	($)				1,130	110
24 Average payment for out-of-country, in-patient insured hospital services	($)				857.0	0.0
25 Average payment for out-of-country, out-patient insured hospital services	($)				226.0	110.0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	(#)				27	21
27. Number of insured surgical-dental services provided by participating dentists.	(#)				0	not available
28. Total payments to dentists for insured surgical-dental services.	($)				0	not available
29. Average payment per service for insured surgical-dental services.	($)				0.0	not available

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners					85	59
b. specialists					79	55
c. other					0	0
d. total					164	114
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners					not available	0
b. specialists					not available	0
c. other					not available	0
d. total					not available	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners					not available	0
b. specialists					not available	0
c. other					not available	0
d. total					not available	0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners					not available	61,074
b. specialists					not available	29,485
c. other					not available	0
d. total					not available	0
34. Number of insured physician services provided, by category of service:	(#)					
a. medical					not available	not available
b. surgical					not available	not available
c. diagnostic					not available	not available
d. other					not available	not available
e. total					not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners					2,323,234	2,494,221
b. specialists					1,146,522	1,229,811
c. other					not available	0
d. total					3,469,756	3,724,032
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical					not available	not available
b. surgical					not available	not available
c. diagnostic					not available	not available
d. other					not available	not available
e. total					not available	not available
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners					not available	40.8
b. specialists					not available	41.0
c. other					not available	0.0
d. all physicians					not available	40.9
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical					not available	not available
b. surgical					not available	not available
c. diagnostic					not available	not available
d. other					not available	not available
e. all services					not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)				not available	55,389
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)				not available	3,232,940
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)				not available	58.0

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	(#)				1	0
43. Total payments for out-of-country insured physician services.	($)				0	0
44. Average payment per service for out-of-country insured physician services.	($)				0.0	0.0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Annex B – Canada Health Act and Extra-Billing and User Charges Information Regulations

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original act, which includes any amendments that have been made since the Act's passage.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. These regulations are also presented in an office consolidation format.

This unofficial consolidation is current to June 2001.

CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6

L.R. (1985), ch. C-6

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

June, 2001

Juin 2001

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

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CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health services

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

throughout Canada by assisting the provinces in meeting the costs thereof;

Now therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *«dentiste»*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *«services complémentaires de santé»*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory health care service;

"extra-billing" *«surfacturation»*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime d'assurance-santé»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel de la santé»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

«assuré» *"insured person"*

«assuré» Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

«contribution» [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » *"cash contribution"*

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*.

«dentiste» *"dentist"*

«dentiste» Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

«frais modérateurs» *"user charge"*

«frais modérateurs» Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

acute, rehabilitative or chronic care, but does not include

(a) a hospital or institution primarily for the mentally disordered, or

(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *« services hospitaliers»*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(b) nursing service,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the hospital,

(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(f) medical and surgical equipment and supplies,

(g) use of radiotherapy facilities,

(h) use of physiotherapy facilities, and

(i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *« services de santé assurés»*

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" *« assuré»*

"insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,

(b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

«habitant» Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province. «habitant» *"resident"*

«hôpital» Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception : «hôpital» *"hospital"*

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux,

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

«loi de 1977» [Abrogée, 1995, ch. 17, art. 34]

«médecin» Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice. «médecin» *"medical practitioner"*

«ministre» Le ministre de la Santé. «ministre» *"Minister"*

«professionnel de la santé» Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit. «professionnel de la santé» *"health care practitioner"*

«régime d'assurance-santé» Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés. «régime d'assurance-santé» *"health care insurance plan"*

«services complémentaires de santé» Les services définis dans les règlements et offerts aux habitants d'une province, à savoir : «services complémentaires de santé» *"extended health care services"*

a) les soins intermédiaires en maison de repos,

b) les soins en établissement pour adultes,

c) les soins à domicile,

d) les soins ambulatoires.

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement. «services de chirurgie dentaire» *"surgical-dental services"*

(c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" *« médecin »*

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" *«ministre»*

"Minister" means the Minister of Health;

"physician services" *« services médicaux »*

"physician services" means any medically required services rendered by medical practitioners;

"resident" *« habitant »*

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" *«services de chirurgie dentaire»*

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" *«frais modérateurs»*

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11.

«services de santé assurés» *"insured health services"*

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

«services hospitaliers» *"hospital services"*

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

«services médicaux» *"physician services"*

«services médicaux» Services médicalement nécessaires fournis par un médecin.

«surfacturation» *"extra-billing"*

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

FL

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;

(b) comprehensiveness;

(c) universality;

(d) portability; and

(e) accessibility.

1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à

amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour de services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Consentement préalable à la prestation des services de santé assurés facultatifs

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

(3) Pour l'application du paragraphe (2), «services de santé assurés facultatifs» s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Définition de «services de santé assurés facultatifs»

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas

Accessibilité

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)*(c)* shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph *(a)*, conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph *(b)* may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c)* si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a)*, soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b)*, sauf par une loi de la province.

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre

may reasonably require for the purposes of this Act; and

(b) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

DEFAULTS

MANQUEMENTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas

a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Modification des décrets

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Avis

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Entrée en vigueur du décret

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Nouvelle application des réductions ou retenues

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le

Application aux exercices ultérieurs

that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

EXTRA-BILLING AND USER CHARGES

SURFACTURATION ET FRAIS MODÉRATEURS

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs *(a)* to *(d)* of the definition "extended health care services" in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13*(a)* and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13*(b)*.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

RÈGLEMENTS

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a)* à *d)* de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13*a)* et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13*b)*.

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)*(a)* or *(b)* except with the agreement of each of the provinces.

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)*a)* ou *b)* qu'avec l'accord de chaque province.

Consentement des provinces

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)*(a)* if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)*a)* s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1er avril 1984.

Exception

Consultation with provinces

(4) No regulation may be made under paragraph (1)*(c)* or *(d)* unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

(4) Il ne peut être pris de règlements en vertu des alinéas (1)*c)* ou *d)* que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

Consultation des provinces

REPORT TO PARLIAMENT

RAPPORT AU PARLEMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

Rapport annuel du ministre

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it as no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(*a*) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the *Extra-billing and User Charges Information Regulations*.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; *(Loi)*

"Minister" means the Minister of National Health and Welfare; *(ministre)*

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. *(exercice)*

TYPES OF INFORMATION

3. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13*a)* DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

«exercice» La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. *(fiscal year)*

«Loi» La *Loi canadienne sur la santé*. *(Act)*

«ministre» Le ministre de la Santé nationale et du Bien-être social. *(Minister)*

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(a) in respect of the estimates referred to in paragraphs 3*(a)* and 4*(a)*, before April 1 of the fiscal year to which they relate; and

(b) in respect of the financial statements referred to in paragraphs 3*(b)* and 4*(b)*, before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3*(a)* and 4*(a)* before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a)* et 4*a)*, avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b)* et 4*b)*, avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3*a)* et 4*a)*, avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

Annex C - Policy Statements: The Epp Letter and the Federal Policy on Private Clinics

Annex C contains the texts for both the Epp Letter and the Marleau Letter (Federal Policy on Private Clinics). While the *Canada Health Act* sets out the criteria, conditions and provisions that provinces and territories must meet in order to qualify for full cash contributions under the Canada Health and Social Transfer, these two documents are acknowledged as providing the federal position related to the interpretation of those criteria, conditions and provisions.

Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp Letter remains an important reference for interpretation of the Act.

On January 6, 1995, federal Minister of Health Marleau wrote to all provinces and territories, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. The charging of user fees is a violation of the *Canada Health Act* and cause for deductions to be made from the annual federal cash contribution payable to each province or territory.

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985

OTTAWA, K1A 0K9

Sent to all Ministers of Health (except the Minister for Quebec, who received an equivalent letter in French on July 15, 1985)

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the Canada Health Act. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the Canada Health Act, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priori-ties of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role - both financial and otherwise - to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the Canada Health Act does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the Canada Health Act, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the Canada Health Act is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the Canada Health Act is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the Canada Health Act.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the Canada Health Act does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the Canada Health Act is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the Canada Health Act.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the Canada Health Act. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding

access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the Canada Health Act is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the Canada Health Act without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the Canada Health Act to their respective health care insurance plans. At the same time, I believe that all provincial/ territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;

2. to reply on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;

3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the Canada Health Act;

4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partner-ship committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the Canada Health Act to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the Canada Health Act to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;

2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the Canada Health Act.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth on page 6.

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the Federal Post-Secondary Education and Health Contributions Act (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the Canada Health Act. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp

Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system - resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to

ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.
I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

Annex D - Deductions and Refunds Under the Canada Health Act

Annex D details the deductions and refunds made to provincial and territorial transfer payments since the passage of the *Canada Health Act* in 1984.

Table 1 presents annual deductions from transfer payments by province and territory, while Table 2 summarizes all deductions and refunds since the Act came into force. In 2000-2001 deductions of $58,000 were made to transfer payments under the Canada Health and Social Transfer for the Province of Nova Scotia with respect to user fees.

Refunds of deductions were permitted during the first three years of the Act under Section 20(5), where provinces were deemed to have eliminated extra-billing and user charges.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/ Territory	1984-85[1]		1985-86[1]		1986-87[1]		1987-1992		1992-93		1993-94		1994-95	
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges
Newfoundland and Labrador							There were no deductions during this period.							
Prince Edward Island														
Nova Scotia														
New Brunswick	63	3,015	84	3,222	206	296								
Quebec		7,893		6,139										
Ontario	39,996		55,328		13,332									
Manitoba	810		460											
Saskatchewan	1,451		656											
Alberta	8,109	1,827	9,216	2,640	5,878	1,362								
British Columbia		22,797		30,620		31,332			83		1,223		676	
Yukon														
Northwest Territories														
Nunavut														
Provincial/Territorial Total	50,429	35,532	65,744	42,621	19,416	32,990			83		1,223		676	

[1] These monies were subsequently reimbursed pursuant to Section 20.(5) of the *Canada Health Act*, for extra-billing and user charges deductions made during the period 1984-85 to 1986-87.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act (continued)

(in thousands of dollars)

Province/ Territory	1995-96		1996-97		1997-98		1998-99		1999-2000		2000-2001		Total Gross Deductions 1984-85 to 2000-2001		
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Total
Newfoundland and Labrador		46		96		128		53						323	323
Prince Edward Island															
Nova Scotia		32		72		57		39		61[2]		58		319	319
New Brunswick													353	6,533	6,886
Quebec														14,032	14,032
Ontario													108,656		108,656
Manitoba		269		588		587		612					1,270	2,056	3,326
Saskatchewan													2,107		2,107
Alberta		2,319		1,266									23,203	9,414	32,617
British Columbia	43												2,025	84,749	86,774
Yukon															
Northwest Territories															
Nunavut															
Provincial/Territorial Total	43	2,666		2,022		772		704		61		58	137,614	117,426	255,040

[2] This is a revision from the number published in the CHA Annual Report for 1999-2000.

Table 2 – Summary of Deductions and Refunds by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/ Territory	Total Gross Deductions 1984-85 to 2000-2001			Refunds 1984-85 to 1986-87			Total Net Deductions 1984-85 to 2000-2001		
	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total
Newfoundland and Labrador		323	323					323	323
Prince Edward Island									
Nova Scotia		319	319					319	319
New Brunswick	353	6,533	6,886	(353)	(6,533)	(6,886)			
Quebec		14,032	14,032		(14,032)	(14,032)			
Ontario	108,656		108,656	(108,656)		(108,656)			
Manitoba	1,270	2,056	3,326	(1,270)		(1,270)		2,056	2,056
Saskatchewan	2,107		2,107	(2,107)		(2,107)			
Alberta	23,203	9,414	32,617	(23,203)	(5,829)	(29,032)		3,585	3,585
British Columbia	2,025	84,749	86,774		(84,479)	(84,749)	2,025		2,025
Yukon									
Northwest Territories									
Nunavut									
Provincial / Territorial Total	137,614	117,426	255,040	(135,589)	(111,143)	(246,732)	2,025	6,283	8,308

Annex E - Evolution of Federal Transfers and the Canada Health and Social Transfer

Since the federal government began contributing to provincial and territorial health insurance programs in 1958, the arrangements for these contributions have evolved. Prior to 1977, the federal government cost shared hospital and physician services with the provinces and territories. In 1977, cost sharing was replaced by block funding (Established Programs Financing - EPF). Then, on April 1, 1996, the Canada Health and Social Transfer (CHST) replaced the EPF and the Canada Assistance Plan (CAP) and continues to provide support through both cash and tax transfers for health and other social programs delivered by the provinces and territories. These arrangements are described in the following section. Further information of federal fiscal programs and arrangements are available from the Department of Finance.

Cost Sharing

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (passed in 1966, came into effect in 1968), the federal contribution in support of medical care was 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory.

Established Programs Financing (EPF)

In 1977, cost-sharing arrangements were replaced by Established Programs Financing. Unlike the previous cost-sharing arrangements, EPF was a block-funding system, no longer open-ended, although funding was from the start and for most of EPF history, tied to economic growth under various formulae.

Under EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. Except for the first few years, the EPF (cash plus tax transfers) was distributed among provinces and territories on an equal per capita basis.

Tax transfers were calculated based on the value of income tax points transferred by the federal government to the provinces and territories in 1977 (13.5 personal income tax points and one corporate income tax point).

EPF cash funds were transferred monthly to each province and territory, provided the provincial/territorial plan satisfied the criteria and conditions set out in the *Canada Health Act*.

In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion total EPF entitlements (cash and tax), 71.2 percent of which was intended for health care and the rest for post-secondary education.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced the Canada Health and Social Transfer, which replaced the EPF and the Canada Assistance Plan (CAP), the federal provincial cost-sharing plan for social services. When the CHST came into effect in 1996, provinces and territories received the same share of the CHST that they had received under the Canada Assistance Plan (CAP), and health and post-secondary education funding made under Established Programs Financing. The provincial and territorial distribution that existed under the previous programs was carried over into the CHST, but has been gradually adjusted to more closely reflect each province and territory's share of the Canadian population.

The CHST is a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments in support of health, post-secondary education, and social services/ assistance programs.

For fiscal year 2000-2001, CHST payments amounted to $32 billion in the form of tax point transfers and cash contributions (Source: Finance Canada, October 2001).

Making CHST Payments

The Department of Finance has been responsible for making CHST payments to the provinces and territories since April 1, 1996. However, the Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance in advance of the payment dates. The Department of Finance then makes the actual deductions from the twice-monthly CHST payments to the provinces and territories.

Annex F - Glossary of Terms Used in the Annual Report

The terms described in this glossary are defined within the context of the Canada Health Act. In other situations, these terms may have different definition or interpretation.

Term	Explanation
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health insurance plans of provinces and territories provide: • insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; • payment for insured health services according to a system of payment authorized by the law of the province or territory; • reasonable compensation to physicians and dentists for all the insured health care services they provide; and • payment to hospitals to cover the cost of insured health care services.
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Bed	An acute care bed is a bed in a health care facility that has been designated for the treatment or care of an in-patient with an acute disease or health condition.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Approved Bed Complement	Number of beds that a health care facility has been approved to operate in order to meet health service delivery expectations. Approval is by the province, territory or the federal government in the case of a federal hospital.
Average In-Patient Per Diem Cost	This is the estimated average amount that a province or territory establishes as the average daily cost of an in-patient treatment or a stay in a health care facility.
Block Fee	This is a fee charged by a physician for services that are uninsured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.

Term	Explanation
Canada Health Act	The *Canada Health Act* received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which replaced the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer.
Canada Health and Social Transfer	The Canada Health and Social Transfer (CHST) is the largest federal transfer to provinces and territories, providing them with cash payments and tax transfers in support of health care, post-secondary education, social assistance and social services. The tax transfer component of the CHST occurred in 1977 when the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates, thus allowing them to raise their tax rates by the same amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments. The CHST gives provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the *Canada Health Act* and the condition that there be no period of minimum residency with respect to social assistance. The CHST came into effect on April 1, 1996, replacing the Canada Assistance Plan (CAP), which cost-shared provincial and territorial social assistance and social service programs, and Established Programs Financing (EPF), which provided funding to support health care and post-secondary education.
Chronic Care	Chronic care is care required by a person who is chronically ill or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable and who requires a range of services and medical management that can only be provided by a hospital.
Chronic Care Bed	A chronic care bed is a bed designated for ongoing in-patient, long-term medical services.
Chronic Care Facility	A chronic care facility is a facility providing ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.
Comprehensiveness	A criterion of the *Canada Health Act* (section 9), which states that the health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where provided by law in a province or territory, services rendered by other health care practitioners.
Consultation Process	Under Section 14(2) of the *Canada Health Act*, the Minister of Health must consult with a province or territory with respect to a potential breach of the five criteria and two conditions of the Act, before discretionary penalties can be levied for that province or territory.
Convention Refugee	A Convention Refugee is a person who has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group or political opinion. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.

Term	Explanation
Coordinating Committee on Reciprocal Billing	The Coordinating Committee on Reciprocal Billing (CCRB), comprised of federal, provincial and territorial government health officials, was formed in 1991 to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of the provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory when travelling or during educational leave or temporary employment.
Day Surgery Bed	A day surgery bed is a bed in a health care facility designated for short-term (less than 24 hours) surgical services.
Diagnostic Physician Service	A diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer be made when a breach any of the five criteria or two conditions of the *Canada Health Act* have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.
Epp Letter	Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp Letter (see Annex C) remains an important reference for interpretation of the Act.
Established Programs Financing (EPF)	Introduced in 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, also known as the *EPF Act*, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories. The EPF was a block-funding system that was tied to economic and population growth. Under the EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. In 1996, the EPF was replaced by the Canada Health and Social Transfer.
Extended Health Care Services	Section 2 of the *Canada Health Act* defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.

Term	Explanation
Extra-billing	This is defined as billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Extra-billing and User Charges Information Regulations	Under the Extra-billing and User Charges Information Regulations of the *Canada Health Act* (see Annex B), provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Marleau wrote to all provinces and territories, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. The charging of user fees is a violation of the CHA and cause for deductions to be made from the annual federal cash contribution payable to each province or territory. The Marleau Letter is included in Annex C of this annual report.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	Health care insurance plan means, in relation to a province or territory, a plan or plans established by the law of the province to provide insured health services.
Health Insurance Supplementary Fund	This is a fund, administered by the Canada Health Act Division, to assist individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*.
Hospital	A hospital is a health care facility located in Canada that provides medical or surgical treatment for the sick or injured, including acute, rehabilitative or chronic care, but does not include an institution primarily for the mentally disordered, nor does it include a facility or portion thereof that provides nursing home care, adult residential care, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between provinces or territories that allows for the reciprocal processing of out-of-province or territory claims for hospital in- and out-patient services. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or the Coordinating Committee on Reciprocal Billing (CCRB).

Term	Explanation
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Service	The *Canada Health Act* defines insured health services as hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any act of the legislature of a province that relates to Workers' Compensation.
Insured Hospital Services	Insured hospital services are interpreted from the *Canada Health Act* as any of the following services provided to in- or out-patients at a hospital or health care facility, if the services are medically necessary, for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability. These are: • accommodation and meals at the standard or public ward level and preferred accommodation if medically required; • nursing service; • laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; • drugs, biologicals and related preparations when administered in the hospital; • use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; • medical and surgical equipment and supplies; • use of radiotherapy facilities; • use of physiotherapy facilities; and • services provided by persons who receive remuneration from the hospital or health care facility.
Insured Person	An insured person is interpreted under the *Canada Health Act* as a resident of a province or territory other than: • a member of the Canadian Forces, • a member of the Royal Canadian Mounted Police who is appointed to rank therein, • a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or • a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services.
Insured Physician Service	This is a medically required service covered by a provincial or territorial health insurance plan and administered by a medical practitioner.
Insured Surgical-Dental Service	The *Canada Health Act* defines surgical-dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure.
Length of Stay	This is the number of days a patient is admitted to a health care services facility.

Term	Explanation
Mandatory Penalties	Provinces that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from federal transfer payments. Mandatory penalties are outlined in sections 20 to 21 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer be made when a breach any of the extra-billing and user charges provisions of the *Canada Health Act* has been identified and could not otherwise be resolved through consultations between the respective levels of government.
Medical Practitioner	Medical practitioner means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between provinces and territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licensed physician. Where an agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physicians	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at the provincial or territorial rate. The provincial or territorial plans reimburse these patients for charges up to, but not more than the amount paid by the plan for that service under fee schedule agreements.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Care	Out-patient diagnostic care includes health care services in a health care facility for procedures that do not require an overnight stay and that detect or determine various diseases or health conditions.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician/Dentist	These are licensed physicians or dentists who are enrolled in provincial or territorial health insurance plans.
Physician Services	For purposes of the *Canada Health Act*, physician services means any medically required services rendered by medical practitioners.
Portability	This criterion of the *Canada Health Act* (section 11) requires that provincial and territorial health insurance plans not impose any minimum period of residence, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period imposed by the health care insurance plan of another province or territory.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.

Term	Explanation
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends and/or profits to its owners, shareholders, operators or members.
Private (not-for-profit) Health Care Facility	This is a privately owned health care facility that is recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Provision of Information Condition	The *Canada Health Act* (section 13 (a)) requires that provincial and territorial governments provide information to the federal minister of health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of administering the Act.
Public Administration Criterion	This criterion of the *Canada Health Act* (section 8) requires that provincial and territorial health care insurance plans be administered and operated on a non-profit basis, by public authorities responsible to the provincial or territorial governments, and be subject to audits of their accounts and financial transactions.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides publicly insured health care services on an in- or out-patient basis.
Recognition Condition	The *Canada Health Act* (section 13(b)) requires that provinces and territories give recognition to the Canada Health and Social Transfer in any public documents, advertisements or promotional material relating to insured health care services and extended health services in that province or territory.
Refugee Claimant	A refugee claimant is a person who has arrived in Canada and who requests refugee status. If a refugee claimant receives a final determination that he or she has been determined to be a Convention Refugee, he or she may then apply for permanent residence.
Rehabilitative Bed	This is a bed designated for in-patient, rehabilitative treatment services in a hospital setting (e.g., rehabilitative treatment for spinal or head injuries).
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required for a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	This is a person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.
Separations	This is the total number of in- and out-patients released from a health facility following discharge, transfer, day surgery or death.

Term	Explanation
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include, but are not limited to, anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, opthalmology, paediatrics, plastic surgery, radiology and urology.
Staffed Beds	This is the number of beds for which a health care facility has staff to provide health services.
Surgical Day Care	Surgical day care includes health care services involving medical operative procedures delivered in a health care facility that do not require an overnight stay for post-operative recovery or observation.
Surgical Physician Service	For purposes of reporting on the *Canada Health Act*, a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	This is where a person is absent from the province or territory of origin for business, education, vacation or other reasons, without assuming permanent residence.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges for items such as alcohol swabs, instruments and sutures that are associated with the provision of an insured physician service.
Universality	This criterion of the *Canada Health Act* (section 10) requires that provincial and territorial health care insurance plans entitle all insured persons in the province or territory to insured services on uniform terms and conditions.
User Charge	This is any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health insurance plan, but does not include any charge imposed by extra-billing.

How to Contact Provincial and Territorial Departments of Health

Newfoundland and Labrador
Newfoundland Medical Care Plan
P.O. Box 200, Elizabeth Towers
100 Elizabeth Avenue
St. John's, Newfoundland A1C 5J3
(709) 292-4000
www.gov.nf.ca/mcp/

Prince Edward Island
Director, Acute and Continuing Care
16 Garfield Street
P.O. Box 2000
Charlottetown, PEI C1A 7N8
(902) 368-6184
www.gov.pe.ca/hss/aacc-info/

Nova Scotia
Director, Inter-Agency Initiatives
Office of the Deputy Minister
Nova Scotia Department of Health
P.O. Box 488
Halifax, NS B3J 2R8
(902) 424-5868
www.gov.ns.ca/health/

New Brunswick
Department of Health and Wellness
P.O. Box 5100
Fredericton, New Brunswick E3B 5G8
(506) 453-2536
www.gnb.ca/HW-SM/hw/

Quebec
Ministère de la Santé et des Services Sociaux
1075, chemin Sainte-Foy, r.-c.
Québec (Québec) G1S 2M1
1-800-707-3380
www.msss.gouv.qc.ca/
www.ramq.gouv.qc.ca/eng/cit/

Ontario
Ministry of Health and Long-Term Care
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4
1-800-268-1153
www.gov.on.ca/health/

Manitoba
Client Service Centre
Manitoba Health
300 Carlton Street
Winnipeg, Manitoba R3B 3M9
1-800-392-1207
www.gov.mb.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, Saskatchewan S4S 6X6
1-800-667-7766
www.health.gov.sk.ca/ps_benefits.html

Alberta
Alberta Health Care Insurance Plan
P.O. Box 1360
Edmonton, AB T5J 2N3
(780) 427-1432 (Edmonton)
www.health.gov.ab.ca/ahcip/

British Columbia
Ministry of Health Services
PO Box 9050 Stn Prov Govt
Victoria, British Columbia V8W 9E2
1-800-661-4337
www.healthservices.gov.bc.ca
health@moh.hnet.bc.ca

Yukon
Yukon Health Care Insurance
P.O. Box 2703
Whitehorse, Yukon Y1A 2C6
www.hss.gov.yk.ca/hsframe.html

Northwest Territories
Health Services Administration
Department of Health and Social Services
Government of N.W.T.
Bag Service # 9 Inuvik, NT X0E 0T0
1-800-661-0830 or 1-867-777-7400
www.hlthss.gov.nt.ca/programs/benefits.htm

Nunavut
Government of Nunavut
Department of Health and Social Services
P.O. Box 1000 Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
www.gov.nu.ca/hss.htm

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Loi canadienne sur la santé

Rapport annuel 2000-2001

Canada

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Division de la Loi canadienne sur la santé

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Par courriel : medicare_hc@hc-sc.gc.ca

Écrivez-nous à l'adresse suivante :

Division de la Loi canadienne sur la santé
0908C1 Édifice Brooke-Claxton
Parc Tunney
Ottawa (Ontario) K1A 0K9
Canada

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Minister of Health Ministre de la Santé

The Honourable/L'honorable A. Anne McLellan

Ottawa, Canada K1A 0K9

Son Excellence la très honorable Adrienne Clarkson,
Gouverneure générale et Commandante en chef du Canada

Qu'il plaise à Votre Excellence,

J'ai l'honneur de présenter à Votre Excellence le rapport annuel sur l'application de la *Loi canadienne sur la santé* pour l'exercice qui s'est terminé le 31 mars 2001.

Je vous prie d'agréer, Madame la Gouverneure générale, l'assurance de mon profond respect.

A. Anne McLellan

Canada

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Santé Canada tient à souligner le travail et les efforts qui ont été investis dans la production du présent rapport annuel. Le dévouement et la diligence des ministères de la Santé énumérés ci-dessous, et de leur personnel, auront permis de présenter le présent rapport sur l'administration et l'application de la *Loi canadienne sur la santé*.

Ministère de la Santé et des Services communautaires de Terre-Neuve et du Labrador

Ministère de la Santé et des Services sociaux de l'Île-du-Prince-Édouard

Ministère de la Santé de la Nouvelle-Écosse

Ministère de la Santé et du Mieux-être du Nouveau-Brunswick

Ministère de la Santé et des Services sociaux du Québec

Ministère de la Santé et des Soins de longue durée de l'Ontario

Ministère de la Santé du Manitoba

Ministère de la Santé de la Saskatchewan

Ministère de la Santé et du Mieux-être de l'Alberta

Ministère des Services de santé de la Colombie-Britannique
Ministère de la Planification de la santé de la Colombie-Britannique

Ministère de la Santé et des Services sociaux du Yukon

Ministère de la Santé et des Services sociaux des Territoires du Nord-Ouest

Ministère de la Santé et des Services sociaux de Nunavut

Nous désirons souligner également le travail considérable réalisé par l'équipe de production : le personnel de l'unité de l'éditique, les services de traduction, de révision et de concordance, ainsi que le personnel de Santé Canada, à l'Administration centrale et dans les bureaux régionaux.

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Introduction

Les cinq principes de la *Loi canadienne sur la santé* sont la pierre angulaire du système de soins de santé canadien, et les Canadiennes et Canadiens en conviennent. Cette Loi, adoptée à l'unanimité par le Parlement en 1984, atteste de l'engagement du gouvernement fédéral à maintenir un système d'assurance-santé fondé sur l'universalité, l'accessibilité, l'intégralité, la transférabilité et la gestion publique. La *Loi canadienne sur la santé* a pour but de veiller à ce que tous les résidents du Canada aient accès aux services hospitaliers et médicaux nécessaires sans avoir à débourser directement pour ces services. La *Loi* énonce les conditions d'octroi et les conditions de versement que les provinces et les territoires doivent respecter pour recevoir la totalité des contributions pécuniaires dans le cadre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS).

Le présent rapport est produit conformément aux exigences énoncées à l'article 23 de la *Loi canadienne sur la santé*, à savoir :

> « Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement. »

Les provinces et les territoires sont tenus de fournir des renseignements sur le fonctionnement de leurs régimes d'assurance-santé, notamment en ce qui a trait au respect des conditions d'octroi et de versement énoncées dans la *Loi*. La collecte de ces renseignements s'est faite sous le signe de la collaboration : les provinces, les territoires et le gouvernement fédéral ont conjugué leurs efforts pour fournir l'information dont le ministre fédéral de la Santé a besoin pour s'acquitter de ses responsabilités.

Le chapitre 1 donne un aperçu de la *Loi canadienne sur la santé* et de l'information concernant son administration, interprétation et application. Le chapitre 2 présente des descriptions des régimes d'assurance-santé des provinces et des territoires liées aux programmes et aux services relevant de la *Loi canadienne de la santé* pour l'exercice finissant le 31 mars 2001. Six annexes, dont la liste apparaît ci-après, sont également jointes au rapport et fournissent une gamme de renseignements supplémentaires concernant l'administration de la *Loi* et du système canadiens de soins de santé.

Des données statistiques sur les services hospitaliers, médicaux et de chirurgie dentaires assurés dans chaque province et territoire figurent dans l'annexe A. Un exemplaire de la *Loi canadienne sur la santé* et de son règlement (consolidation non officielle en juin 2001) figurent dans l'annexe B. L'annexe C présente des exemplaires de deux énoncés de principes clés qui clarifient l'interprétation fédérale des conditions d'octroi et de versement de la *Loi canadienne sur la santé*. L'annexe D résume les déductions et les remboursements effectuées sur les transferts fédéraux en vertu de la *Loi*. L'annexe E décrit l'évolution des transferts fédéraux pour les soins de santé au Canada. L'annexe F est un glossaire des termes utilisés dans le présent rapport. À l'intérieur de la couverture arrière, vous trouverez les coordonnées des ministères provinciaux et territoriaux de la Santé.

Chapitre 1 – Loi canadienne sur la santé : aperçu, administration, interprétation, conformité et retenues

L'accomplissement dont nous sommes le plus fiers en ce qui a trait au bien-être des Canadiennes et des Canadiens a été d'affirmer que la maladie en elle-même était un malheur assez grand en soi, pour que la ruine financière ne vienne pas s'y ajouter. C'est pourquoi l'assurance-maladie apparaît comme un principe sacré et nous ne permettons pas qu'il soit violé.

(Juge Emmett M. Hall)

Aperçu

Qu'est-ce que la Loi canadienne sur la santé ?

La *Loi canadienne sur la santé* est la loi fédérale qui régit l'assurance-santé.

La politique canadienne des soins de santé a pour principal objectif de protéger, de promouvoir et de rétablir le bien-être physique et mental des résidents du Canada, et de leur donner, dans des conditions raisonnables, accès aux services de santé, sans que des obstacles financiers ou d'un autre ordre s'y opposent.

La *Loi canadienne sur la santé* établit les conditions d'octroi et de versement applicables aux services de santé assurés et aux services complémentaires de santé que doivent respecter les provinces et les territoires pour avoir droit au versement intégral de la contribution pécuniaire au titre du Transfert canadien en matière de santé et de programmes sociaux.

La *Loi canadienne sur la santé* a pour objet de veiller à ce que tous les résidents admissibles du Canada aient, selon des conditions raisonnables, accès aux services assurés qui sont médicalement nécessaires sans avoir à débourser directement pour ces services au point de service.

Quels sont les services de santé couverts en vertu de la Loi ?

Deux groupes de services sont définis en vertu de la *Loi canadienne sur la santé* :

- les services de santé assurés,
- les services complémentaires de santé.

Les services de santé assurés sont les services hospitaliers, médicaux et de chirurgie dentaire médicalement nécessaires qui sont fournis aux personnes assurées.

Aux termes de la *Loi canadienne sur la santé*, les services hospitaliers assurés désignent les services médicalement nécessaires fournis dans un hôpital à des malades hospitalisés ou externes, tels que l'hébergement régulier ou en salle commune, les services infirmiers, certains actes de diagnostic comme les tests sanguins et les radiographies, l'administration des médicaments fournis à l'hôpital aux patients, et l'utilisation des salles d'opération, des salles d'accouchement et des installations d'anesthésie.

Au sens de la *Loi*, les services médicaux assurés sont les « services médicalement nécessaires fournis par un médecin ». Les services médicalement nécessaires sont généralement déterminés conjointement par les médecins et par les régimes d'assurance-santé provinciaux et territoriaux.

Les services de chirurgie dentaire sont les services fournis par un dentiste dans un hôpital et qui ne peuvent être offerts convenablement que dans un tel établissement.

Les services complémentaires de santé visés par la *Loi canadienne sur la santé* comprennent les services de soins de longue durée en établissement (les soins intermédiaires en maison de repos et les soins en établissement pour adultes) et les composantes « santé » des soins à domicile et des soins ambulatoires.

Quelles sont les personnes visées par la Loi?

Les personnes assurées sont les résidents admissibles d'une province. Au sens de la *Loi canadienne sur la santé*, un résident est une « personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province ».

Les personnes non visées par la *Loi canadienne sur la santé* sont les membres des Forces canadiennes et de la Gendarmerie royale du Canada, et les personnes purgeant une peine d'emprisonnement dans un pénitencier fédéral.

Exigences de la Loi canadienne sur la santé

En vertu de la *Loi canadienne sur la santé*, les provinces et territoires doivent satisfaire à neuf exigences pour avoir droit au versement intégral de la contribution pécuniaire du gouvernement fédéral. Ces neuf exigences sont les suivantes :

- cinq conditions d'octroi s'appliquant uniquement aux services de santé assurés;
- deux conditions de versement s'appliquant aux services de santé assurés et aux services complémentaires;
- des dispositions touchant la surfacturation et les frais modérateurs, qui s'appliquent uniquement aux services de santé assurés.

Les critères

1. **Gestion publique**

   Ce critère s'applique aux régimes d'assurance-santé des provinces et des territoires (et non aux hôpitaux ou aux autres établissements qui offrent des services hospitaliers). Les régimes d'assurance-santé doivent être gérés par une autorité publique sans but lucratif nommée ou désignée par le gouvernement de la province ou du territoire, relevant de ce gouvernement, et assujettie à la vérification de ses comptes et de ses opérations financières.

2. **Intégralité**

   Le régime provincial ou territorial d'assurance-santé doit couvrir tous les services de santé assurés (fournis par les hôpitaux, les médecins ou les dentistes) et, lorsque la loi de la province ou du territoire le permet, certains services fournis par d'autres professionnels de la santé.

3. **Universalité**

   Absolument tous les résidents assurés de la province ou du territoire ont droit aux services de santé assurés offerts par le régime d'assurance-santé selon des modalités uniformes. Les provinces et territoires exigent généralement que les résidents s'inscrivent au régime pour être admissibles aux services offerts.

   Les nouveaux arrivants au Canada, tels que les résidents permanents et les Canadiens qui rentrent au pays après avoir séjourné dans d'autres pays, peuvent être assujettis à un délai d'au plus trois mois avant d'être admissibles ou d'avoir droit aux services de santé assurés.

4. **Transférabilité**

   Les résidents qui déménagent dans une autre province ou un autre territoire continuent d'être protégés par le régime de leur province ou territoire « d'origine » pendant la période d'attente minimale imposée par le régime de la nouvelle province ou du nouveau territoire de résidence, jusqu'à concurrence de trois mois. Après ce délai, la nouvelle province ou le nouveau territoire de résidence assume la couverture des soins de santé.

Les résidents temporairement absents de leur province, territoire ou pays d'origine, doivent aussi continuer d'avoir droit aux services de santé assurés. De la sorte, les personnes peuvent voyager ou s'absenter de leur province, territoire ou pays d'origine dans des limites prescrites, mais continuer d'être assurées par leur régime d'assurance-santé.

La transférabilité n'autorise pas une personne à obtenir des services dans une autre province, un autre territoire ou un autre pays. Elle a plutôt pour objet de permettre l'admissibilité d'une personne aux services nécessaires en cas de besoin urgent ou nouveau lorsque celle-ci est absente temporairement, par exemple pour des raisons d'affaires ou pour des vacances.

Lorsque des personnes assurées sont temporairement absentes parce qu'elles sont dans une autre province ou un autre territoire, les services assurés doivent être payés selon les tarifs de la province d'accueil. Si des personnes assurées sont temporairement absentes du pays, les services assurés doivent être payés selon les tarifs prévus dans la province d'origine.

Pour que la protection s'étende à certains services électifs (non urgents), un résident d'une province qui est temporairement absent de celle-ci peut être tenu d'obtenir l'approbation préalable du régime d'assurance-santé.

5. Accessibilité

Les régimes d'assurance-santé des provinces et des territoires doivent assurer :

- l'accès raisonnable aux services de santé assurés, selon des modalités uniformes et sans qu'il soit restreint, directement ou indirectement, par des frais modérateurs, une surfacturation ou d'autres moyens (p. ex., la discrimination fondée sur l'âge, l'état de santé ou la situation financière). Aux termes de la *Loi canadienne sur la santé*, l'accès raisonnable sur le plan de la disponibilité physique des services médicalement nécessaires doit être interprété selon la règle « du lieu où les services sont offerts et de leur disponibilité ». Ainsi, les résidents d'une province ou d'un territoire ont le droit d'accéder aux services de santé assurés là où les services sont offerts et selon la disponibilité de ces services;
- la rémunération raisonnable des médecins et des dentistes pour tous les services de santé assurés qu'ils fournissent;
- le versement aux hôpitaux de montants destinés à défrayer les services de santé assurés.

Conditions de versement

Renseignements — Aux fins de la *Loi canadienne sur la santé*, les administrations provinciales et territoriales sont tenues de communiquer au ministre de la Santé, selon des modalités raisonnables, des renseignements touchant les services de santé assurés et les services complémentaires de santé.

Reconnaissance — Les administrations provinciales et territoriales doivent faire état, de façon appropriée, de la contribution fédérale aux services de santé assurés et aux services complémentaires de santé.

Surfacturation et frais modérateurs

Surfacturation — Il y a surfacturation lorsqu'un médecin ou un dentiste facture directement à une personne assurée un montant pour un service assuré, et que ce montant s'ajoute à celui qui serait normalement versé par le régime d'assurance-santé de la province ou du territoire. Si, par exemple, un médecin demande cinq dollars à ses patients pour une consultation déjà couverte par un régime d'assurance-santé, les cinq dollars demandés constituent une surfacturation.

Frais modérateurs — Il s'agit des frais directs imposés aux patients (autres que la surfacturation) pour des services assurés couverts par le régime d'assurance-santé d'une province, et qui ne sont pas payables, directement ou indirectement, par le régime d'assurance-santé. Si, par exemple, un patient se voit imposer des frais avant d'avoir reçu un traitement au service d'urgence d'un centre

hospitalier, ces frais sont considérés comme étant des frais modérateurs.

Autres éléments de la Loi

Règlements

Le gouverneur en conseil peut passer des règlements en vue de l'application de la *Loi canadienne sur la santé* de sorte que les fins pour lesquelles elle a été énoncée soient atteintes et que les dispositions qu'elle prévoit prennent effet.

Le seul règlement passé en application de la *Loi* est le *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*, qui exige que les provinces et les territoires fournissent des prévisions des montants surfacturés et des frais modérateurs avant le début de l'exercice de sorte que les pénalités applicables puissent être imposées. Selon ce règlement, ils doivent aussi fournir les états financiers indiquant les montants réellement facturés de sorte que les rapprochements avec les retenues réelles puissent être faits. (L'annexe B renferme le texte de ce règlement.)

Pénalités imposées en vertu de la Loi canadienne sur la santé

Pénalités obligatoires

En vertu de la *Loi canadienne sur la santé*, les provinces et territoires qui autorisent la surfacturation et les frais modérateurs s'exposent à une retenue obligatoire d'un montant équivalent sur leurs paiements de transfert fédéraux. Par exemple, si l'on déterminait qu'une province a autorisé les médecins à pratiquer la surfacturation pour un montant total de 500 000 $, ce montant serait retenu sur les paiements de transfert fédéraux versés à cette province.

Pénalités discrétionnaires

Les provinces ou territoires qui ne satisfont pas aux cinq conditions d'octroi et aux deux conditions de versement énoncées dans la *Loi canadienne sur la santé* peuvent se voir imposer des pénalités discrétionnaires. Les montants de ces pénalités sont établis en fonction de la gravité du défaut.

Avant d'imposer toute pénalité discrétionnaire, la *Loi canadienne sur la santé* prescrit le recours à un processus de consultation avec la province ou le territoire visé. Les dispositions touchant les pénalités discrétionnaires prévues par la *Loi* n'ont jamais été appliquées jusqu'ici.

Services de santé non visés par la Loi

En plus des services médicalement nécessaires dispensés par les hôpitaux et les médecins qui sont couverts en vertu de la *Loi canadienne sur la santé*, les provinces et les territoires offrent toute une gamme de services et de prestations qui ne sont pas du ressort de la *Loi*. Ces services et prestations supplémentaires sont dispensés à la discrétion des administrations provinciales et territoriales, selon leurs propres conditions, et ils peuvent varier d'une province ou d'un territoire à l'autre. Parmi ces services supplémentaires, mentionnons des services de soins à domicile, des prestations pour médicaments d'ordonnance, des services ambulanciers, des services d'optométrie et des services de soins dentaires.

Les services supplémentaires offerts par les provinces et territoires peuvent viser des groupes donnés (p. ex., enfants ou aînés) et être assurés en tout ou en partie par les régimes d'assurance-santé provinciaux et territoriaux.

Un certain nombre de services offerts par les hôpitaux et par les médecins ne sont pas considérés comme médicalement nécessaires; ils ne sont donc pas assurés aux termes des lois provinciales et territoriales sur l'assurance-santé. Parmi ces services hospitaliers non assurés pour lesquels des frais peuvent être imposés aux patients, mentionnons l'hospitalisation en chambre privée ou semi-privée, sauf si elle est prescrite par un médecin, les soins infirmiers privés, et la fourniture de téléphones et de téléviseurs. Parmi les services médicaux non assurés pour lesquels les patients peuvent se voir imposer des frais, mentionnons les consultations téléphoniques, la délivrance de certificats médicaux pour l'employeur, l'école, les assureurs ou les centres de culture physique, les témoignages devant les tribunaux et la chirurgie esthétique.

Les services de soins de santé couverts par les lois provinciales sur les accidents du travail ne sont pas du ressort de la *Loi canadienne sur la santé*.

Administration

Division de la Loi canadienne sur la santé

Faisant partie de la Direction des affaires intergouvernementales de la Direction générale de la politique de la santé et des communications de Santé Canada, la Division administre la *Loi canadienne sur la santé* et fournit des conseils stratégiques relativement à cette loi. Elle exerce une surveillance relativement à un vaste éventail de données afin de s'assurer que les provinces et les territoires respectent les conditions d'octroi et de versement prévues par la *Loi*, elle informe le ministre des éventuelles infractions à la *Loi* et elle recommande l'adoption de mesures pertinentes. De plus, la Division interprète les dispositions de la *Loi* et elle offre un soutien aux conseillers juridiques relativement aux affaires judiciaires mettant en cause la *Loi canadienne sur la santé*. Elle tient aussi un centre d'expertise sur le système d'assurance-santé canadien.

De concert avec les bureaux régionaux de Santé Canada, la Division recueille des renseignements sur les différents problèmes, orientations et politiques des provinces et des territoires afin de faciliter l'application de la *Loi*. Les quatre millions de dollars supplémentaires annoncés en mai 2000 par le ministre de la Santé conformément aux recommandations formulées par le vérificateur général en 1999 ont permis d'affecter davantage de personnel à l'application de la *Loi* tant à l'administration centrale que dans les régions, et de renforcer les capacités de Santé Canada en matière d'analyse des politiques et d'établissement de rapports touchant la *Loi canadienne sur la santé*.

Une autre initiative stratégique visant à fournir promptement au ministre des renseignements fiables a été la mise au point d'une méthode plus systématique de collecte, de stockage et d'extraction de renseignements pour la Division de la Loi canadienne sur la santé. Le personnel de Santé Canada situé à l'administration centrale et dans les régions contribue à la tenue du Système d'information sur la Loi canadienne sur la santé grâce à l'examen, à l'analyse et au catalogage des renseignements se rapportant à l'application de la *Loi canadienne sur la santé* et à la prestation de soins de santé au Canada.

La Division répond aux demandes de renseignements du public, des ministères, des organismes intéressés et des médias au sujet de la *Loi*, et aux questions touchant l'assurance-santé, que ces demandes lui soient communiquées par téléphone, par courriel ou par la poste. Au cours de l'exercice 2000-2001, la Division a répondu à plus de 2 000 demandes de renseignements. Le bureau des Relations avec les médias de la Direction générale a également répondu à près de 350 demandes des médias se rapportant à la *Loi canadienne sur la santé*.

La Division compile également des renseignements en vue de leur diffusion auprès des provinces et territoires au moyen du Système d'information sur les services additionnels. Ces renseignements ont trait aux services qui ne sont pas visés par la *Loi canadienne sur la santé* et que les provinces et territoires fournissent aux résidents à leur discrétion ainsi que selon leurs propres conditions.

La Division produit également des renseignements concernant la *Loi* et d'autres sujets liés à l'assurance-santé, qui sont ensuite affichés dans son site Web <www.hc-sc.gc.ca/medicare>. Au cours de l'exercice 2000-2001, le site été consulté en moyenne 4 729 fois par semaine. En d'autres termes, on consulte une page de notre site en moyenne toutes les deux minutes.

De plus, la Division participe aux activités qui suivent.

Comité de coordination de la facturation réciproque

La Division de la Loi canadienne sur la santé préside le Comité fédéral-provincial-territorial de coordination de la facturation réciproque (CCFR) et en assure le secrétariat.

Ce comité, créé en 1991, a pour mandat de cerner et de résoudre les problèmes d'ordre administratif liés aux ententes interprovinciales et interterritoriales sur la facturation réciproque des services médicaux et hospitaliers. Les ententes interprovinciales et interterritoriales sur la facturation réciproque ont, de façon générale, pour objet d'assurer que les Canadiens admissibles aient accès aux services de santé médicalement nécessaires lorsqu'ils sont aiguillés vers de tels services en dehors de leur province ou de leur territoire, lorsqu'ils sont en voyage, ou encore pendant un congé d'études ou un emploi temporaire. Tous les territoires et toutes les provinces participent aux ententes réciproques touchant les soins hospitaliers et tous, à l'exception du Québec, participent à des ententes réciproques touchant les soins médicaux. Ces ententes sont interprovinciales et interterritoriales et non fédérales, et les provinces et territoires ne sont pas tenus de les signer en vertu de la *Loi canadienne sur la santé*.

Un groupe de travail fédéral-provincial-territorial mandaté par le CCFR examine et met à jour l'Accord interprovincial-territorial sur l'admissibilité et la transférabilité, et apporte des éclaircissements d'ordre administratif sur celui-ci. Cet accord fixe les normes minimales en ce qui a trait à l'admissibilité et à la transférabilité interprovinciales-territoriales des régimes d'assurance-santé.

Services diagnostiques d'imagerie par résonance magnétique (IRM) et de tomographie par ordinateur (TO)

L'utilisation accrue des services d'imagerie par résonance magnétique (IRM) et de tomographie par ordinateur (TO) au cours des dernières années reflète l'apparition et l'adaptation des technologies des soins de la santé, qui s'inscrivent dans l'évolution du système canadien de soins de la santé. Pour les fournisseurs de soins de santé publics et privés, ces services font partie d'un système de soins de santé moderne et adapté; toutefois, ils comportent de nombreux défis pour les gouvernements, les fournisseurs de soins et le public pour ce qui est de la gestion des coûts et de la mise en place, et la compréhension de lignes directrices régissant l'accès et la disponibilité des services.

Afin de mieux comprendre ces enjeux, un Groupe de travail fédéral, provincial et territorial sur l'offre, la demande et la prestation des services d'imagerie par résonance magnétique (IRM) et de tomographie par ordinateur (TO) a examiné la prestation des services d'IRM et de TO à l'intérieur du système canadien de soins de santé. Chaque province et territoire a désigné un membre au sein du Groupe de travail (le représentant du Québec a participé à titre d'observateur). L'ancien sous-ministre de Santé Canada a également demandé que le Groupe de travail se penche sur des solutions possibles en vue d'empêcher que des personnes assurées défraient des services de diagnostic de pointe médicalement nécessaires, de tels incidents ayant été porté à l'attention du ministre fédéral de la Santé et constituent une préoccupation compte tenu de la *Loi canadienne sur la santé*.

Le Groupe de travail a défini son mandat de manière à mener à bien deux objectifs : premièrement, élaborer le présent rapport collectif en vue de documenter l'offre, la demande et la prestation de services diagnostiques d'imagerie par résonance magnétique (IRM) et de tomographie par ordinateur (TO) dans toutes les administrations du Canada pour faire le point sur la prestation de ces services au Canada (« rapport de situation »); deuxièmement, soumettre à la Conférence des sous-ministres fédéral, provinciaux et territoriaux de la santé des recommandations sur les moyens d'assurer un accès de niveau adéquat et en temps opportun à ces services diagnostiques, sous des modalités et conditions uniformes, par l'entremise du système public de soins de santé.

Prévention et règlement des différends

Le 10 septembre 2000, l'honorable Allan Rock, ministre fédéral de la Santé, a écrit à l'honorable Gary Mar, ministre de la Santé et du Mieux-être de l'Alberta, pour lui faire part de la volonté du gouvernement fédéral d'entreprendre, parmi les ministres de la Santé, un processus concerté d'élaboration d'un mécanisme de prévention et de règlement des différends liés à la Loi canadienne sur la santé qui est conforme aux engagements pris en vertu de l'Entente-cadre sur l'union sociale (ECUS) et les obligations du gouvernement fédéral en vertu de la LCS.

En octobre 2000, la Conférence des ministres fédéral-provinciaux-territoriaux de la Santé a convenu de créer un groupe de travail fédéral-provincial-territorial pour entreprendre ces travaux et de confier la coprésidence du groupe à Santé Canada et à l'Alberta. Les autres membres du groupe de travail comprennent la Saskatchewan, l'Ontario et Terre-Neuve.

Interprétation, conformité et retenues

Interprétation

Lettre Epp

En juin 1985, le ministre fédéral de la Santé, Jake Epp, a confirmé la politique fédérale d'interprétation et de mise en œuvre de la *Loi canadienne sur la santé* dans une lettre aux provinces et aux territoires. La « Lettre Epp » (voir l'annexe C) demeure une référence importante pour l'interprétation de la *Loi*.

Politique fédérale sur les cliniques privées

Lors de la réunion fédérale-provinciale-territoriale des ministres de la Santé, tenue à Halifax en septembre 1994, tous les ministres étaient présents, à l'exception de celui de l'Alberta. Ils ont alors convenu de « prendre les mesures qui s'imposaient pour réglementer le développement des cliniques privées au Canada ».

Le 6 janvier 1995, la ministre de la Santé, Diane Marleau, a écrit aux ministres de la Santé provinciaux et territoriaux (voir l'annexe C). Elle leur a communiqué l'interprétation fédérale de la *Loi canadienne sur la santé* en ce qui concerne l'imposition directe de frais d'établissement aux patients qui reçoivent des services médicaux nécessaires dans une clinique privée elle-même financée pour ces services par le régime d'assurance-santé de la province ou du territoire. Comme le soulignait la ministre Marleau dans sa lettre, depuis le 15 octobre 1995, les provinces et les territoires jugés en état de contravention par rapport à la politique fédérale sur les cliniques privées se voient imposer des pénalités obligatoires en vertu de la *Loi canadienne sur la santé*. Ces pénalités ont pris la forme de retenues sur les transferts mensuels en espèces dans le cadre du Transfert canadien en matière de santé et de programmes sociaux.

Conformité

Enquêtes

On exerce une surveillance touchant la conformité à la *Loi canadienne sur la santé* en examinant les documents que fournissent les provinces et les territoires dans le cadre du *Rapport annuel sur l'application de la Loi canadienne sur la santé* et les autres types de rapports qu'ils produisent, en examinant les reportages des médias sur la surveillance des questions de santé, et en exerçant un suivi quant aux plaintes et demandes provenant de la population, d'organismes intéressés ou de membres du personnel médical.

La démarche privilégiée par Santé Canada pour le règlement des cas de non-conformité éventuelle met l'accent sur la transparence, la consultation et le dialogue. La plupart du temps, les cas sont réglés par la voie de consultations et de discussions avec les provinces et les territoires, qui sont fondées sur l'examen approfondi des faits. Les pénalités ne sont appliquées que lorsque les autres moyens de résolution ont échoué.

Parmi les trois problèmes de conformité ayant fait l'objet d'une enquête pendant l'exercice 1999-2000, celui du « contournement d'une file d'attente » par un particulier de l'Alberta relativement à une chirurgie de l'œil a été réglé. Pour ce qui est des autres problèmes mentionnés dans le *Rapport annuel sur la Loi canadienne sur la santé de 1999-2000*, des consultations avec les provinces concernées sont en cours.

Problèmes de conformité soulevés en 2000-2001

Au cours de l'exercice 2000-2001, Santé Canada a mené des enquêtes relativement à trois problèmes : la prestation de services d'avortement, les frais modérateurs et les services d'imagerie à résonance magnétique (IRM) offerts dans les cliniques privées.

Services d'avortement

Le gouvernement fédéral continue d'unir ses efforts à ceux des gouvernements provinciaux et territoriaux afin de veiller à ce que, dans toutes les provinces où des cliniques d'avortement existent, ce service soit offert aux résidents en tant que service entièrement assuré et selon des conditions uniformes.

Les fonctionnaires de Santé Canada et du ministère de la Santé et du Bien-être du Nouveau-Brunswick se sont réunis en janvier 2001 afin de discuter de ce problème. Les échanges de renseignements sur ce sujet se poursuivent entre les deux paliers de gouvernement.

Des problèmes liés à l'avortement ne sont pas encore réglés à l'Île-du-Prince-Édouard, au Québec et au Manitoba. Dans chacun des cas, les fonctionnaires de Santé Canada ont abordé la question auprès de leurs homologues provinciaux.

Frais modérateurs

En juin 2000, Santé Canada a appris qu'un résident assuré de la Colombie-Britannique avait acheté des services de santé assurés auprès d'un centre de chirurgie privé de la province, sous le couvert d'un tiers payeur. Pour ce faire, la personne a contourné la file afin de recevoir le traitement.

Les fonctionnaires de Santé Canada et de la Colombie-Britannique ont échangé de la correspondance à ce sujet. Les travaux sur cette question se poursuivent toujours.

Imagerie à résonance magnétique (IMR)

On trouve des cliniques privées offrant des services d'IRM en Colombie-Britannique, en Alberta et au Québec. Le problème soulevé est celui des frais imposés aux patients dans ces cliniques pour des services IRM médicalement nécessaires. Santé Canada poursuit des discussions à cet égard et continue d'échanger des renseignements concernant la prestation de services IRM et d'autres services diagnostiques de pointe afin de veiller à ce que les patients ne se voient pas imposer des frais pour ces services lorsqu'ils sont médicalement nécessaires.

Retenues

En ce qui concerne 2000-2001, on a réduit de 4 817 $ par mois le montant versé au titre du Transfert canadien en matière de santé et de programmes sociaux à la Nouvelle-Écosse, ce qui représente une réduction de 57 804 $ pour l'année. Cette pénalité obligatoire a été imposée à la Nouvelle-Écosse parce qu'elle n'avait pas versé les frais d'établissement imposés pour des avortements pratiqués dans une clinique privée. Il s'agit de la seule province à qui une pénalité a été imposée en 2000-2001 pour non-conformité à la *Loi canadienne sur la santé*.

L'annexe D renferme un tableau détaillé de toutes les pénalités discrétionnaires et obligatoires imposées en vertu de la *Loi canadienne sur la santé*. L'annexe E fournit des renseignements additionnels sur le Transfert canadien en matière de santé et de programmes sociaux.

Chapitre 2 – Les Régimes d'assurance-santé des provinces et des territoires en 2000-2001

Au cours de l'exercice 2000-2001, les régimes d'assurance-santé des provinces et des territoires ont continué d'offrir l'accès à une gamme complète de services hospitaliers et médicaux, ainsi qu'à des services complémentaires de santé. Les renseignements présentés ici ont été fournis par les provinces et les territoires. Ils servent à situer l'exploitation des régimes d'assurance-santé offerts pendant l'exercice se terminant le 31 mars 2001 par rapport aux dispositions de la *Loi canadienne sur la santé*.

Toutes les provinces et tous les territoires fournissent certains services de santé qui ne sont pas prévus par la *Loi canadienne sur la santé*. Parmi ces services complémentaires, mentionnons l'assurance-médicaments, les soins à domicile, les services ambulanciers et les aides à la vie autonome. Ces services sont offerts à la discrétion des provinces et des territoires, selon leurs propres modalités.

Le présent chapitre a pour objet de démontrer dans quelle mesure les régimes d'assurance-santé des provinces et des territoires ont satisfait aux exigences prévues par la *Loi canadienne sur la santé* pendant l'exercice visé. Afin d'aider à assurer l'uniformité et l'intégralité de l'information, Santé Canada a demandé aux fonctionnaires provinciaux et territoriaux de préparer leur documentation au moyen d'un gabarit que le Ministère a conçu en collaboration avec des représentants de chaque province et territoire. Les fonctionnaires provinciaux et territoriaux devaient fournir une description de leurs régimes d'assurance-santé respectifs en respectant les domaines d'activité énoncés dans la *Loi canadienne sur la santé*. De plus, Santé Canada leur a demandé de décrire les moyens pris par leur gouvernement pour reconnaître la contribution financière du gouvernement fédéral aux services de santé assurés et aux services complémentaires de santé, conformément aux dispositions de la *Loi canadienne sur la santé*. Enfin, les fonctionnaires devaient décrire la gamme de services complémentaires de santé offerts par leur province ou territoire, par exemple les soins intermédiaires en maison de repos, les soins en établissement pour adultes, les soins à domicile et les soins de santé ambulatoires.

À la suite d'un examen mené avec les provinces et les territoires et portant sur les renseignements présentés en vue de la préparation du rapport annuel de 1999-2000, on a reconnu qu'il était nécessaire d'apporter d'autres améliorations afin d'assurer l'intégralité, l'uniformité et l'exactitude des renseignements présentés dans le nouveau rapport. Une autre modification apportée à l'établissement des rapports pour 2000-2001 a été la présentation par les provinces et les territoires de documents publiés et d'autres données ayant trait aux cinq conditions d'octroi de la *Loi canadienne sur la santé* de même qu'à la condition de reconnaissance. Ces documents et ces données nous ont été transmis par les provinces et les territoires ou ont été trouvés dans le site Web des administrations provinciales ou territoriales.

Veuillez noter que la description du régime d'assurance-santé du Québec a été présentée conformément au format utilisé dans les versions précédentes du *Rapport annuel sur la Loi canadienne sur la santé*. Le Québec a choisi de ne pas présenter ces renseignements selon la manière et avec tous les détails requis par Santé Canada, comme il est mentionné dans la préface à la description narrative du régime d'assurance-santé du Québec.

Terre-Neuve et Labrador

Introduction

Quatorze conseils régionaux assurent la plupart des services de santé à Terre-Neuve et au Labrador. De ceux-ci, huit sont des conseils de santé en établissement, quatre sont des conseils de services communautaires et deux sont des conseils intégrés, qui assurent tous deux des services en établissement et des services communautaires. Parmi les huit conseils de santé en établissement, il y a un conseil provincial pour les services aux cancéreux et un conseil régional pour les maisons de repos, tous deux situés à St. John's.

C'est le gouvernement provincial qui nomme les membres bénévoles des conseils de santé. Ces conseils sont responsables de la prestation des services de santé dans les régions et, dans certains cas, dans l'ensemble de la province. Les conseils consultent le public afin de déterminer les besoins de santé et de donner suite aux questions d'intérêt public. Ils obtiennent leur financement du gouvernement provincial auquel ils doivent rendre compte de leurs activités. Le ministère de la Santé et des Services communautaires assure une orientation stratégique aux conseils et surveille les programmes et les services.

À Terre-Neuve et au Labrador, près de 20 000 fournisseurs et administrateurs de soins de santé offrent des services de santé aux 536 400 résidents de la province.

La planification de l'avenir du système de soins de santé de la province repose sur une vision claire des grands enjeux sanitaires pour la province :

- l'escalade rapide des coûts qui menace l'abordabilité du régime d'assurance-santé;
- une population vieillissante qui nécessite généralement plus de services que les groupes de personnes plus jeunes;
- le coût des nouveaux médicaments et de la technologie de pointe;
- les hausses de salaires et d'honoraires dans les autres provinces qui donnent lieu à des pressions pour les augmenter à Terre-Neuve et au Labrador;
- la nécessité d'investir davantage dans l'intervention précoce et la prévention afin de promouvoir le mieux-être.

La planification comprendra un processus décisionnel reposant sur les principes de l'accessibilité, de la qualité, de la responsabilité et de la durabilité. Les grands secteurs de planification comprennent la structure des services de santé, le financement et les ressources humaines; la concentration sur le mieux-être; le modèle de prestation des services de santé; et la responsabilisation.

Faits saillants des activités entreprises en 2000-2001

Le gouvernement de Terre-Neuve et du Labrador a fait un investissement considérable dans les soins de santé en 2000-2001 : les dépenses au titre des services de santé et des services communautaires représentent maintenant environ 42 p. 100 de toutes les dépenses des programmes gouvernementaux. La somme de 136 millions de dollars a été engagée en dépenses nouvelles pour l'exercice 2000-2001.

Le budget total des services de santé et des services communautaires pour 2000-2001 s'élevait à près de 1,3 milliard de dollars, le plus important budget de tous les ministères du gouvernement de la province.

Une équipe d'examen spéciale a été établie en 2000-2001 afin de travailler avec les conseils institutionnels pour identifier les services de base, les priorités, les nouvelles orientations et les économies. Les travaux de l'équipe d'examen et des conseils ont joué un rôle essentiel dans la détermination de façons d'optimiser le système de santé de la province et de commencer à définir le système de l'avenir.

En 2000-2001 le gouvernement a affecté la somme de 23,7 millions de dollars à la modernisation du matériel diagnostique et thérapeutique des établissements de santé. De cette somme, 8,8 millions de dollars proviennent du gouvernement en vertu de l'Entente des premiers ministres sur le renouvellement du système de santé. Les achats comprendront du nouveau matériel et du matériel de remplacement en vue d'améliorer la capacité de traitement des malades et de réduire les désavantages liés aux déplacements dans certaines régions rurales.

Au cours des cinq dernières années, des centaines de millions de dollars ont été engagés au titre de la construction de nouveaux établissements de santé et de la rénovation des établissements existants.

La somme de 138 millions de dollars a été affectée à la rénovation des principaux services hospitaliers de St. John's, laquelle doit être terminée en 2001. St. John's est le centre principal vers lequel sont aiguillés les patients de tous les secteurs de Terre-Neuve et du Labrador.

Les travaux de rénovation comprennent la construction du nouveau Janeway Children's Health and Rehabilitation Centre qui offrira des installations pour malades hospitalisés, pouvant accueillir 103 enfants, le transfert des services de soins actifs pour adultes du Grace General Hospital au St. Clare's Mercy Hospital et au Health Sciences Centre, ainsi que la fermeture du Grace General Hospital. Des améliorations ont également été apportées au Miller Centre pour un coût additionnel de 2,6 millions de dollars.

Outre la rénovation entreprise à St. John's, deux nouveaux établissements ont ouvert leurs portes dans d'autres régions de la province en 2000-2001. Happy Valley-Goose Bay compte maintenant un centre de soins de santé de 24 lits qui a coûté 30,5 millions de dollars. Le nouveau centre de soins de santé de Harbour Breton, qui comprend 21 lits pour sa part, a coûté 8,4 millions de dollars.

Des services communautaires améliorés ont également été créés dans le cadre de la mise en œuvre de la nouvelle *Child, Youth and Family Services Act*, et par le truchement d'autres initiatives comme le Programme de la prestation nationale pour enfants. De plus, le gouvernement a approuvé la somme de 410 000 $ au cours de l'exercice 2000-2001 pour appuyer les enfants souffrant d'autisme. Cette somme s'insère dans le cadre de l'engagement de 2,2 millions de dollars échelonnés sur trois ans, prévu pour les enfants autistes de Terre-Neuve et du Labrador.

Le gouvernement a également affecté la somme additionnelle de 300 000 $ en 2000-2001 au titre de la mise en œuvre d'une stratégie de réduction du tabagisme, et a maintenu son engagement à réduire le tabagisme chez les jeunes. Cette somme fait partie de l'engagement de 900 000 $ échelonnés sur trois ans et visant à réduire le tabagisme dans la province.

La somme de un million de dollars a été affectée en 2000-2001 aux augmentations des subsides et des tarifs prévus pour les entreprises de soins à domicile.

Le gouvernement a approuvé la somme de 3,3 millions de dollars pour l'amélioration des services ambulanciers routiers de la province.

Près de un million de dollars a été approuvé pour poursuivre les projets pilotes à Happy Valley-Goose Bay, à Twillingate et à Port-aux-Basques afin de tenter de trouver des façons innovatrices d'assurer les soins de santé primaires par le truchement d'une approche concertée en matière de santé et de mieux-être.

La somme de six millions de dollars a été consentie pour remplacer l'ancienne ambulance aérienne *King Air 100* par une *King Air 350*.

Des fonds additionnels de 5,4 millions de dollars ont été prévus pour la couverture de médicaments nouveaux et éprouvés en vertu du régime d'assurance-médicaments de la province, et pour une utilisation accrue.

Le gouvernement a affecté la somme de 600 000 $ afin de verser des incitatifs aux nouvelles infirmières diplômées qui s'engagent à travailler dans la province. Le gouvernement a également affecté la somme de 75 000 $ d'un programme de 225 000 $ échelonné sur trois ans pour aider les infirmières étudiantes à acquérir de l'expérience dans les régions rurales de la province. La somme de 1,2 million de dollars a été allouée pour l'embauche de diplômées du programme des infirmières praticiennes.

La somme de 2,1 millions de dollars a été inscrite au budget pour embaucher de nouveaux médecins salariés. Cette somme est venue s'ajouter à un financement annualisé d'environ 8,5 millions de dollars prévu en 1999-2000 pour plus de 50 médecins salariés. Une somme additionnelle de 1,9 million de dollars a été ajoutée aux 32 millions de dollars prévus par le protocole d'entente sur les services médicaux de 2000-2001 en raison du nombre accru de médecins rémunérés à l'acte dans la province.

Des renseignements additionnels sur la santé et les soins de santé à Terre-Neuve et au Labrador sont disponibles dans le site Web du ministère de la Santé et des Services communautaires <www.gov.nf.ca/health/>.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Les régimes d'assurance-santé gérés par le ministère de la Santé et des Services communautaires comprennent le régime d'assurance-hospitalisation et le régime d'assurance-soins médicaux (RASM). Les deux régimes sont sans but lucratif et sont vérifiés par le vérificateur général de la province.

La *Hospital Insurance Agreement Act*, amendée en 1994, est la loi qui régit le régime d'assurance-hospitalisation. Cette loi précise que le ministre peut établir des règlements relatifs à la prestation des services assurés aux résidents de la province, selon des modalités et conditions uniformes et conformément aux dispositions de la *Loi canadienne sur la santé* et des règlements y afférents. Les principales dispositions incluent les règlements sur l'assurance-hospitalisation.

La *Medical Care Insurance Act* (1999) a été sanctionnée le 14 décembre 1999 et est entrée en vigueur le 1er avril 2000. Cette loi a remplacé la *Medical Care Insurance Act* qui était en vigueur auparavant. Essentiellement, la nouvelle loi a aboli la Medical Care Commission qui détenait auparavant la responsabilité de l'administration du RASM et elle a créé la Division du régime d'assurance-soins médicaux (RASM) au sein du ministère de la Santé et des Services communautaires.

La Division du RASM facilite la prestation de soins médicaux complets à tous les résidents de la province grâce à l'établissement de politiques, de procédures et de systèmes qui permettent de compenser les fournisseurs de façon adéquate pour la prestation de services professionnels assurés.

La Division agit conformément aux dispositions de la *Medical Care Insurance Act* (1999) et des règlements y afférents de même qu'en conformité avec les critères de la *Loi canadienne sur la santé*.

1.2 Liens hiérarchiques

La Direction des services de soutien du ministère de la Santé et des Services communautaires a le mandat d'administrer le régime d'assurance-santé et le régime d'assurance-médicaments. Le ministère rend compte des activités de ces régimes au moyen des processus législatifs habituels, par exemples les comptes publics.

Le gouvernement a élaboré le *Strategic Social Plan* (SSP) afin d'être en mesure d'évaluer les progrès réalisés dans l'atteinte de ses objectifs et de présenter des rapports publics sur les résultats. Une méthode de vérification des politiques et d'autres déterminants ayant un impact sur les besoins sociaux est en voie de développement. Selon cette méthode, les indicateurs du processus mesurent le

rendement tandis que les indicateurs d'incidence mesurent les résultats. La responsabilité du gouvernement de rendre des comptes publics sur les soins de santé représente une part importante du volet vérification du SSP.

En septembre 2000, le gouvernement a mis en place un cadre stratégique sur l'imputabilité des organismes publics, dont les conseils de santé, ce qui permettra d'améliorer la planification, la surveillance du rendement et la présentation de rapports. Dans le secteur de la santé, le cadre stratégique sur l'imputabilité aidera à s'assurer d'une utilisation efficace et efficiente des ressources financières et humaines pour répondre aux besoins de la population et améliorer le rendement du système de santé.

1.3 Vérification des comptes

Chaque année, le Vérificateur général de la province effectue un examen autonome des comptes publics de la province. Les dépenses du RASM sont maintenant considérées comme faisant partie des comptes publics. Le Vérificateur général dispose d'un accès complet et illimité aux dossiers du RASM.

Les conseils d'administration des hôpitaux sont soumis à des vérifications des états financiers, à des missions d'examen et à des vérifications de la conformité aux autorisations légales. Les vérifications des états financiers sont effectuées par des firmes de vérification indépendantes choisies par les conseils, conformément aux dispositions de la *Public Tendering Act*. Les missions d'examen et les vérifications de la conformité aux autorisations légales sont effectuées par le personnel du ministère de la Santé et des Services communautaires. Des vérifications auprès des médecins sont effectuées par le ministère de la Santé et des Services communautaires, en vertu de la *Medical Care Insurance Act* (1999) de Terre-Neuve. Les dossiers des médecins sont étudiés afin de garantir qu'ils correspondent bien aux services facturés et que ces services sont assurés en vertu du régime d'assurance-santé.

Des vérifications auprès des assurés sont effectuées par le personnel du ministère de la Santé et des Services communautaires, en vertu de la *Medical Care Insurance Act* (1999) de Terre-Neuve. Les personnes sont choisies au hasard à toutes les deux semaines.

Le *Newfoundland Medical Care Commission Annual Report* de l'exercice 1999-2000, qui a été rendu public à l'automne de l'année 2000, faisait le point sur 48 vérifications de fournisseurs en voie de réalisation relativement au régime d'assurance-soins médicaux au 31 mars 2000. De plus, 113 vérifications auprès d'assurés en étaient à diverses étapes d'achèvement à la fin de l'année. Un rapport du vérificateur général de la province est inclus dans le *Newfoundland Medical Care Commission Annual Report*.

2.0 Intégralité

2.1 Services hospitaliers assurés

La *Hospital Insurance Agreement Act* (1990) et le *Hospital Insurance Regulations* (1996) régissent les services hospitaliers assurés de Terre-Neuve et du Labrador.

Les services hospitaliers assurés sont fournis par 32 établissements répartis dans l'ensemble de la province. Les services aux malades hospitalisés comprennent :

- l'hébergement et la fourniture des repas en salle commune;
- les services infirmiers;
- les services de laboratoire et de radiologie, et les autres services de diagnostic;
- les produits pharmaceutiques, substances biologiques et préparations connexes;
- les fournitures médicales et chirurgicales, les salles d'opération, les salles d'accouchement et les installations d'anesthésie;
- les services de réadaptation (par ex., physiothérapie, praxithérapie, orthophonie et audiologie).

Les services assurés aux malades externes comprennent :

- les services de laboratoire et de radiologie, et les autres services de diagnostic;
- les services de réadaptation,
- les consultations externes et d'urgence;
- les chirurgies d'un jour,
- les produits pharmaceutiques, substances biologiques et préparations connexes médicalement nécessaires administrés à l'hôpital.

2.2 Services médicaux assurés

La loi qui régit les services médicaux assurés est la *Medical Care Insurance Act* (1999).

Les règlements applicables en vertu de la *Medical Care Insurance Act* comprennent :

- le *Medical Care Insurance Insured Services Regulations*;
- le *Medical Care Insurance Beneficiaries and Inquiries Regulations*; ainsi que;
- le *Medical Care Insurance Physician and Fees Regulation*.

Les médecins habilités ont l'autorisation de fournir les services médicaux assurés en vertu du régime d'assurance de Terre-Neuve et du Labrador. Pour pratiquer dans la province, un médecin doit détenir un permis émis par le Newfoundland Medical Board (conseil des médecins de Terre-Neuve).

En 2000-2001, 755 médecins rémunérés à l'acte ont donné des services assurés rémunérés à l'acte dans la province.

Les médecins peuvent décider de ne pas participer au régime d'assurance-santé, de la façon décrite dans le paragraphe 1 de l'article 12 de la *Medical Care Insurance Act* (1999) :

« Si un médecin donnant des services assurés n'est pas un médecin participant[1], il n'est pas soumis à la présente *Loi* ni aux règlements relatifs à la prestation de services assurés ou au paiement de ces services au moment où il fournit un service assuré à un patient, sauf qu'il doit :

a) avant de donner le service assuré, s'il désire se réserver le droit de facturer le patient pour le service en question d'un montant qui excède celui payable par le Ministère en vertu de la présente *Loi*, informer le patient qu'il n'est pas un médecin participant et qu'il peut donc facturer le patient directement;

b) fournir au patient à qui il a donné le service assuré les renseignements exigés par le Ministère pour qu'il autorise le versement au patient du paiement du service assuré, en vertu de la présente *Loi*. » [*trad. libre*]

Aux fins de l'application de la *Loi*, les services suivants sont couverts :

- tous les services donnés de façon justifiée et adéquate par des médecins à des patients souffrant d'une maladie qui exige un traitement ou un conseil médical;
- les immunisations ou inoculations de groupe effectuées par des médecins à la demande d'une autorité compétente;
- les services de laboratoire, de radiologie et autres services de diagnostic fournis dans des hôpitaux, approuvés par une autorité compétente, et qui ne sont pas fournis en vertu de la *Hospital Insurance Agreement Act* et des règlements y afférents.

Il n'existe aucune restriction quant aux services couverts, pourvu qu'ils respectent l'une ou plus d'une des conditions décrites plus haut.

En 2000-2001, aucun service n'a été ajouté à la liste des services médicaux assurés couverts par le régime d'assurance-santé de Terre-Neuve et du Labrador.

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[1] La *Medical Care Insurance Act, 1999* entend par « médecin participant » un médecin qui a pas choisi, en vertu du paragraphe 7(3), de se faire rembourser pour les services assurés qu'il fournit aux résidents de la province par le Ministre et personne d'autre.

Il faut obtenir une directive du ministère pour ajouter un service médical à la liste de services assurés. Ce processus a été entrepris à la suite de consultations menées par le ministère auprès de divers intervenants, y compris auprès de l'association médicale provinciale. Il devrait y avoir une consultation publique.

2.3 Services de chirurgie dentaire assurés

Les traitements de chirurgie dentaire justifiés et adéquats, fournis à un assuré par un dentiste dans un l'hôpital, sont couverts par le RASM si le traitement est d'un type précisé dans la liste de services de chirurgie dentaire assurés.

Tous les dentistes détenteurs d'un permis de pratiquer à Terre-Neuve et au Labrador et qui bénéficient de privilèges hospitaliers sont autorisés à donner des services de chirurgie dentaire. Le permis de pratiquer la chirurgie dentaire est émis par le Newfoundland Dental Licensing Board (conseil de réglementation sur les soins dentaires de Terre-Neuve).

Les dentistes peuvent opter pour le retrait du régime. Dans ce cas, ils doivent informer les patients de leur statut de dentistes non participants, en précisant les frais auxquels les patients doivent s'attendre et en leur fournissant un dossier écrit sur les services et les frais facturés. Un seul dentiste fait actuellement partie de la catégorie des dentistes non participants.

L'ajout d'un service de chirurgie dentaire dans la liste des services assurés est soumis à l'approbation du ministère de la Santé et des Services communautaires.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Les services hospitaliers non couverts par le régime comprennent :

- l'hébergement en chambre privée ou semi-privée à la demande du patient;
- la chirurgie esthétique ou autres services jugés non médicalement nécessaires;
- le transport en ambulance ou autre transport de patient qui a lieu avant l'admission à l'hôpital ou au moment du congé;
- les soins infirmiers privés demandés par le patient;
- les radiographies non médicalement nécessaires ou autres services demandés pour des raisons reliées à l'emploi ou à l'assurance;
- les médicaments (à l'exception des médicaments anti-rejet et de l'AZT) et appareils prescrits pour usage après le congé de l'hôpital;
- les téléphones, radios ou téléviseurs destinés à un usage personnel et non à des fins éducatives;
- les attelles de fibre de verre;
- les services couverts par les lois sur l'indemnisation des travailleurs ou par toute autre loi fédérale ou provinciale;
- les services reliés aux avortements thérapeutiques effectués dans des établissements non autorisés ou non approuvés par le Newfoundland Medical Board.

L'utilisation des installations hospitalières pour tout service jugé non assuré par le régime d'assurance-santé serait aussi non assurée en vertu du régime d'assurance-hospitalisation.

En vertu de la *Medical Care Insurance Act* (1999), les services médicaux suivants ne sont pas assurés :

- tout conseil donné au téléphone par un médecin à un patient;
- la distribution par un médecin de produits médicinaux, médicaments ou appareils médicaux ainsi que la remise ou la rédaction d'ordonnances médicales;
- la préparation par un médecin de dossiers, rapports ou certificats pour un patient ou en son nom, ou encore toute communication avec un patient ou ayant trait à un patient;
- tout service rendu par un médecin à son épouse ou à ses enfants;

- tout service auquel un patient a droit en vertu d'une loi du Parlement du Canada,d'une loi de la province de Terre-Neuve et du Labrador, d'une loi de n'importe quelle province ou territoire du Canada, ou de toute loi étrangère.
- le temps pris ou les dépenses engagées pour se déplacer afin de donner une consultation à un patient;
- les services ambulanciers et les autres formes de transport de patients;
- l'acuponcture et tous les actes et services relatifs à l'acupuncture, à l'exclusion d'une évaluation initiale spécifiquement reliée au diagnostic de la maladie qu'on se propose de traiter par acupuncture;
- les examens non nécessités par la maladie ou effectués à la demande d'une tierce partie, sauf s'ils sont précisés par l'autorité compétente.
- la chirurgie plastique ou toute autre chirurgie effectuée à des fins purement esthétiques, à moins qu'elle ne soit médicalement indiquée;
- le témoignage en Cour;
- les consultations d'optométristes, d'omnipraticiens ou d'ophtalmologistes qui ont pour seul but de déterminer si des lunettes ou verres de contact nouveaux ou de remplacement sont requis;
- les honoraires des dentistes, chirurgiens dentaires ou omnipraticiens pour des extractions dentaires de routine effectuées à l'hôpital;
- le traitement dentaire au fluorure pour les enfants de moins de 4 ans;
- l'excision de xanthélasmas;
- la circoncision des nouveau-nés;
- l'hypnothérapie;
- l'examen médical pour les conducteurs;
- les traitements de toxicomanies effectués à l'extérieur du Canada;
- la consultation exigée par les règlements de l'hôpital;
- les avortements thérapeutiques effectués dans la province, mais dans un établissement non approuvé par le Newfoundland Medical Board;
- le réassignement sexuel chirurgical, lorsqu'il n'est pas recommandé par le Clarke Institute of Psychiatry;
- la fertilisation in vitro et la stimulation ovarienne accompagnée d'un transfert de sperme;
- la réperméabilisation tubaire ou la vaso-vasostomie;
- le diagnostic chirurgical ou les actes thérapeutiques non fournis dans les établissements autres que ceux qui sont mentionnés dans la liste de la *Hospitals Act* ou approuvés en vertu du paragraphe 3 (d);
- les autres services qui ne sont pas couverts par l'article 3 de la *Loi*.

Tous les services de diagnostic (p. ex., les services de laboratoire et de radiographie) sont fournis dans les établissements publics de la province. La politique hospitalière sur l'accès assure qu'un accès prioritaire n'est pas accordé aux tierces parties.

Les fournitures et services médicaux mis en place et associés à un service assuré sont fournis aux patients gratuitement et conformément aux normes nationales régissant la pratique. Les patients conservent le droit d'améliorer les fournitures ou services médicaux réguliers en payant davantage. Les normes concernant les fournitures médicales sont élaborées par les hôpitaux qui donnent ces services, en consultation avec les fournisseurs du service.

Les services de chirurgie dentaire et les autres services non couverts par le *Dental Health Plan*, sont les honoraires du dentiste, du chirurgien stomatologiste ou de l'omnipraticien pour les extractions dentaires de routine effectuées à l'hôpital de même que pour le traitement dentaire au fluorure des enfants âgés de moins de six ans.

3.0 Universalité

3.1 Admissibilité au régime

Les résidents de Terre-Neuve et du Labrador sont admissibles à la couverture offerte en vertu du régime de soins de santé provincial.

La *Medical Care Insurance Act* (1999) définit un « résident » comme une personne légalement autorisée à vivre ou à rester au Canada et qui réside dans la province, ou qui y vit habituellement, à l'exclusion des personnes qui font du tourisme, sont de passage ou en visite dans la province.

Le *Medical Care Insurance Beneficiaries and Inquiries Regulations* établit les résidents admissibles à la couverture offerte en vertu des régimes. En tant qu'administrateur des règlements, le RASM a établi des règles pour s'assurer que dans le traitement des demandes, les règlements sont appliqués de façon cohérente et juste.

Les personnes non admissibles à la couverture offerte en vertu des régimes comprennent :

- les étudiants et leurs personnes à charge qui sont déjà couverts par une autre province ou territoire;
- les personnes à charge des résidents, si elles sont couvertes par une autre province ou territoire;
- les réfugiés, ceux qui ont demandé qu'on leur accorde le statut de réfugié et leurs personnes à charge;
- les travailleurs étrangers détenant des permis de travail ainsi que leurs personnes à charge qui ne répondent pas aux critères établis;
- les étudiants étrangers et leurs personnes à charge;
- les personnes qui font du tourisme, sont de passage ou en visite ainsi que leurs personnes à charge;
- le personnel des Forces canadiennes et de la Gendarmerie royale du Canada;
- les détenus sous responsabilité fédérale;
- le personnel des Forces armées d'autres pays stationné dans la province.

3.2 Exigences relatives à l'inscription au régime

Pour avoir accès aux services assurés, il faut s'inscrire en vertu du régime d'assurance-soins médicaux et posséder une carte d'assurance-santé valide. Les nouveaux résidents sont avisés de faire leur demande d'inscription aussi rapidement que possible après leur arrivée à Terre-Neuve ou au Labrador.

L'inscription d'un nouveau-né ou d'un enfant adopté relève des parents. Les parents d'un nouveau-né se verront remettre une formule de demande d'inscription au moment du congé de l'hôpital. Dans la plupart des cas, les demandes de couverture pour un nouveau-né devront être accompagnées du numéro de RASM valide des parents. Si le nom de famille de l'enfant diffère de celui des parents, un certificat de naissance ou de baptême sera exigé.

Les demandes de couverture pour un enfant adopté devront être accompagnées d'une copie des documents d'adoption officiels, du certificat de naissance de l'enfant ou d'un avis de placement en vue d'une adoption émis par le ministère de la Santé et des Services communautaires. Les demandes de couverture pour un enfant ayant été adopté à l'extérieur du Canada devront être accompagnées des documents de résident permanent de l'enfant.

Au 11 avril 2001, un total de 616 944 assurés actifs étaient inscrits au Régime d'assurance-soins médicaux de la province.

3.3 Autres catégories de personnes

Les travailleurs étrangers, les ecclésiastiques étrangers, les membres de l'OTAN, les détenteurs de permis ministériels et les membres de leur famille sont admissibles à la couverture de l'assurance-santé.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes assurées dans une autre province ou un autre territoire qui déménagent à Terre-Neuve ou au Labrador sont admissibles à la couverture à compter du premier jour du troisième mois suivant le mois de leur arrivée.

Les personnes qui arrivent de l'extérieur du Canada pour établir leur résidence dans la province sont admissibles à la couverture le jour même de leur arrivée. Les mêmes règles s'appliquent aux membres des Forces canadiennes et de la GRC qui prennent leur retraite et aux détenus libérés de pénitenciers fédéraux. Cependant, pour que la couverture soit effective, il est nécessaire de s'inscrire en vertu du Régime d'assurance-soins médicaux. Une couverture immédiate est accordée aux personnes de l'extérieur du Canada qui sont autorisées à travailler dans la province pour une année ou plus.

4.2 Couverture durant des absences temporaires (au Canada)

Une couverture est offerte aux résidents de la province quand ils s'absentent temporairement de la province mais qu'ils restent au Canada. La province a conclu des ententes officielles avec les autres provinces et territoires pour la facturation réciproque des services hospitaliers assurés. Les coûts de ces services sont remboursés selon des taux normalisés approuvés par la province ou le territoire hôte. Les procédures coûteuses pour le traitement de malades hospitalisé et les services fournis aux malades externes sont remboursés en fonction de taux nationaux auxquels les régimes de santé des provinces et territoires ont consenti.

Dans toutes les provinces et territoires, à l'exception du Québec, les services médicaux assurés sont payés, grâce à une entente de facturation réciproque, aux taux de la province ou du territoire hôte. Les réclamations concernant des services médicaux reçus au Québec sont présentées par le patient à la Newfoundland Medical Care Commission pour paiement aux taux de la province hôte.

Afin d'être admissible à une couverture en dehors de la province, un bénéficiaire doit observer la législation et les règles du RASM en ce qui a trait à la résidence à Terre-Neuve et au Labrador. Pour être assurée, une personne doit résider dans la province pendant au moins 4 mois consécutifs pour chaque période de 12 mois. En général, les règles concernant la couverture médicale et hospitalière durant les absences sont les suivantes :

- avant de quitter la province pour des périodes prolongées, les personnes doivent contacter le RASM pour obtenir un certificat de couverture hors province;
- les assurés quittant la province pour fins de vacances peuvent recevoir un certificat de couverture hors province initial afin d'être couverts pour une période allant jusqu'à 12 mois. À leur retour, les assurés doivent résider dans la province pendant un minimum de quatre mois consécutifs. Par la suite, les certificats émis ne le seront que pour une couverture allant jusqu'à 8 mois;
- les étudiants quittant la province peuvent recevoir un certificat, renouvelable à chaque année, à la condition qu'ils fournissent la preuve de leur inscription dans une école reconnue située hors province;
- les personnes quittant la province pour fins d'emploi peuvent recevoir un certificat couvrant une période allant jusqu'à 12 mois; une vérification de l'emploi peut alors être exigée;
- les personnes ne doivent pas établir leur résidence dans une autre province, un autre territoire ou un autre pays tout en maintenant leur couverture en vertu du Régime d'assurance-soins médicaux de Terre-Neuve;
- pour les voyages hors province d'une durée de 30 jours ou moins, un certificat n'est pas exigé, mais il sera émis sur demande;
- pour les voyages hors province d'une durée de plus de 30 jours, un certificat est exigé. Celui-ci établira que la personne est couverte par le régime durant son absence de la province;

- le fait de ne pas demander la couverture hors province ou de ne pas se soumettre aux règles concernant la résidence peut avoir pour conséquence que le résident doit payer le coût entier de toute facture pour des services médicaux ou hospitaliers reçus hors province.

Les résidents assurés qui déménagent de façon permanente dans d'autres parties du Canada sont couverts jusqu'au dernier jour du deuxième mois suivant le mois de leur départ, ce dernier jour étant inclus. La couverture est immédiatement interrompue quand des résidents déménagent de façon permanente dans d'autres pays.

4.3 Couverture durant des absences temporaires (à l'étranger)

La province offre une couverture à ses résidents durant leurs absences temporaires du Canada. Les services hospitaliers fournis à des malades hospitalisés et à des malades externes à l'extérieur du pays sont couverts en cas d'urgences, de maladies subites et de traitements non urgents, à des taux préétablis. Le montant maximal payable par l'assurance-hospitalisation gouvernementale pour des soins hospitaliers fournis à l'étranger à des malades hospitalisés est de 350 $ par jour si les services assurés sont fournis dans un hôpital communautaire ou régional. Lorsque les services assurés sont fournis dans un hôpital de soins tertiaires (un établissement hautement spécialisé), le taux approuvé est de 465 $ par jour. Le taux approuvé pour des services fournis à des malades externes est de 62 $ par visite; pour l'hémodialyse, le montant approuvé est de 220 $ par traitement. Les taux approuvés sont payés en devises canadiennes.

Les services médicaux sont couverts en cas d'urgences ou de maladies subites de même que pour des services non urgents, s'ils ne sont pas disponibles dans la province ou au Canada. Les services médicaux sont payés au taux qui aurait été payé à Terre-Neuve et au Labrador pour le même service. Si les services ne sont pas disponibles à Terre-Neuve ou au Labrador, ils sont habituellement payés aux taux de l'Ontario ou aux taux s'appliquant dans une province où ils sont disponibles.

4.4 Nécessité d'une approbation préalable

Pour les services assurés médicalement nécessaires donnés par des hôpitaux autorisés ou par des médecins qui habitent dans d'autres provinces ou territoires, aucune autorisation préalable n'est exigée.

Si un résident de la province doit se rendre à l'extérieur du pays pour obtenir des soins hospitaliers spécialisés parce que le service assuré n'est pas disponible au Canada, le régime provincial d'assurance-santé payera le coût des services nécessaires à ses soins. Toutefois, dans de telles circonstances, il faut obtenir une approbation préalable auprès du ministère de la Santé et des Services communautaires. Les médecins orienteurs doivent contacter le ministère ou le RASM pour obtenir une approbation préalable.

Aucune approbation préalable n'est exigée pour les services médicaux; toutefois, il est suggéré que les médecins obtiennent une autorisation préalable auprès du régime, de façon à sensibiliser les patients à l'aspect financier des services. Les omnipraticiens et les spécialistes peuvent demander une approbation préalable au nom de leurs patients. L'approbation préalable n'est pas accordée pour la prestation de services non urgents à l'étranger si ces services sont disponibles dans la province ou au Canada.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

À Terre-Neuve et au Labrador, l'accès aux services de santé assurés est accordé selon des modalités et conditions uniformes. Dans la province, il n'existe aucune exigence de participation aux frais, dans le cas des services hospitaliers, ni aucune surfacturation par les médecins.

5.2 Accès aux services hospitaliers assurés

Au 31 mars 2000, Terre-Neuve comptait 1 643 lits dotés en personnel dans 14 hôpitaux et 18 centres de santé communautaire, y compris 1 467 lits pour soins actifs, 22 lits pour soins de réadaptation et 204 lits pour soins psychiatriques.

Les renseignements sur les lits pour soins actifs utilisés pour les services de soins de jour ne sont pas disponibles.

Le nombre total d'infirmières autorisées exerçant leur profession dans la province en 2000-2001 est de 5 592. Environ 85 p. 100 des plus récentes diplômées ont choisi de rester dans la province et de profiter de la prime de 3 000 $. Cette prime est offerte aux diplômées de 2001 pour une deuxième année et le taux de participation est semblable à celui de l'année dernière.

Douze nouveaux postes d'infirmières praticiennes ont été créés dans les régions rurales, ce qui améliore l'accès du public aux soins de santé primaires. Les postes d'infirmières praticiennes ont augmenté pour passer à plus de 30, un petit nombre de postes spécialisés étant prévu pour les soins tertiaires. Les inscriptions au programme des infirmières auxiliaires autorisées ont augmenté de façon soutenue depuis 1999. Parmi les autres programmes, il convient de mentionner les bourses pour infirmières praticiennes étudiantes, une augmentation de 6 à 9 p. 100 pour les infirmières autorisées et d'environ 3 p. 100 pour les infirmières auxiliaires autorisées suivant un examen des groupes professionnels, un programme d'incitatifs pour les infirmières des régions éloignées et nordiques, et un projet pilote de trois ans pour faciliter les stages des étudiantes infirmières en régions rurales et éloignées.

La Base de données sur les infirmières autorisées de l'Institut canadien d'information sur la santé indique qu'en 2000, le nombre d'infirmières autorisées par rapport au nombre de résidents à Terre-Neuve et au Labrador (100 pour 10 000) était plus élevé que le taux pour l'ensemble du Canada (75,4 pour 10 000). Malgré ce rapport élevé, par 10,000 de population certains hôpitaux ont connu des pénuries de personnel infirmier, particulièrement chez les infirmières ayant une formation spécialisée pour travailler dans le secteur des soins critiques et cardiaques.

Il y a également une pénurie de personnel dans d'autres groupes professionnels comme la physiothérapie, l'orthophonie, l'audiologie, l'ergothérapie et la psychologie. Des mesures de recrutement ciblées et des programmes d'incitatifs sont en place comme les bourses d'études et l'achat de places, et de nouvelles mesures sont à l'étude. Le nombre de psychologues a augmenté grâce à un amendement à la *Psychologists Act* qui a établi la maîtrise comme niveau d'entrée à l'exercice de la profession.

Pour ce qui est de la disponibilité de certains services et matériels diagnostiques, médicaux, chirurgicaux et thérapeutiques dans les établissements offrant des services hospitaliers assurés :

- l'imagerie par résonance magnétique (IRM) n'est offerte qu'à St. John's;
- les tomodensitomètres ne sont disponibles qu'à St. John's (trois appareils), à Clarenville, à Gander, à Grand Falls-Windsor, à Corner Brook et à St. Anthony;
- les services de dialyse rénale sont offerts à St. John's, à Grand Falls-Windsor et à Corner Brook;
- la thérapie anticancéreuse est offerte au *Dr. H. Bliss Murphy Cancer Centre*, à St. John's, et aux cliniques satellites à Gander, à Grand Falls-Windsor, à Corner Brook et à St. Anthony;
- environ 82 p. 100 des services chirurgicaux sont offerts à St. John's, à Gander, à Grand Falls-Windsor, à Corner Brook et à St. Anthony. Une gamme complète de services chirurgicaux de base et certains services chirurgicaux de sous-spécialité sont offerts à tous les endroits; la chirurgie tertiaire, par exemple, la traumatologie, la chirurgie cardiaque et la neurochirurgie sont offertes uniquement à St. John's;

- un autre 18 p. 100 des services chirurgicaux sont offerts dans six hôpitaux de taille moyenne à Carbonear, à Clarenville, à Burin, à Stephenville, à Happy Valley-Goose Bay et à Labrador City. Ces installations offrent des services chirurgicaux de base.

Un certain nombre de mesures importantes ont été prises en 2000-2001 pour améliorer l'accès aux services hospitaliers assurés, notamment :

- l'accès aux services de tomodensitométrie a été amélioré grâce à la prestation de services à Clarenville et à Gander. Des tomodensitomètres additionnels sont prévus pour Carbonear et Happy Valley-Goose Bay en 2001-2002;
- des services de mesure de la densité osseuse sont devenus disponibles à Gander, à Grand Falls-Windsor et à Corner Brook;
- le gouvernement a approuvé un investissement annualisé de 2,7 millions de dollars pour les frais de fonctionnement du programme de soins cardiaques afin de satisfaire à la demande actuelle et future; de plus, la somme de 1,2 million de dollars a été affectée à la rénovation ou à l'achat de matériel cardiaque afin d'améliorer le programme provincial de soins cardiaques. Le programme de St. John's a été élargi pour assurer quelque 150 interventions chirurgicales de plus par année de manière à réduire le temps d'attente;
- des activités de planification et des activités connexes ont été entreprises en vue d'un nouveau service de dialyse rénale communautaire prévu pour juillet 2001;
- de nouveaux hôpitaux ont ouvert leurs portes à Harbour-Breton et à Happy Valley-Goose Bay. Les activités de rénovation des immobilisations et les activités de planification et de conception connexes se poursuivent à Gander, à Fogo, à Stephenville et à Bonne-Bay;
- la somme de 130 000 $ a été allouée au Programme de dépistage du cancer du col dans l'ouest de Terre-Neuve en 2000-2001.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Le nombre de médecins pratiquant dans la province est relativement stable. En ce qui concerne les médecins, le ministère de la Santé et des Services communautaires travaille avec les conseils régionaux de santé à l'élaboration d'un plan de ressources humaines qui repose sur le principe de l'accès aux services.

Afin d'augmenter le recrutement en milieu rural, on a apporté des améliorations aux échelles salariales et accordé des primes de maintien en poste aux médecins salariés, en fonction de leur répartition géographique. De plus, des primes pour les services hospitaliers fournis par des omnipraticiens dans des hôpitaux ruraux ont aussi été accordées.

Les questions relatives aux niveaux de services et à l'accessibilité (temps d'attente) sont étudiées par les conseils régionaux de santé et les corrections nécessaires, par exemple l'augmentation du nombre de chirurgies cardiaques effectuées chaque semaine afin de réduire le temps d'attente, sont effectuées au besoin.

Au cours de 2000-2001, 12 nouveaux médecins ont débuté leur pratique; ceux-ci ont, à un moment donné, bénéficié de l'aide financière accordée par le ministère de la Santé et des Services communautaires au moyen des programmes suivants : un programme de bourses de voyage, un programme de bourses pour les médecins spécialistes résidents, un programme d'incitation à la pratique, destiné aux étudiants en médecine et aux résidents, et un programme de bourses destiné aux résidents en psychiatrie.

En ce qui concerne les services de chirurgie dentaire assurés, quatre dentistes diplômés et un chirurgien stomatologiste non agréé pratiquent dans la province. Un total de 21 dentistes généralistes détiennent des privilèges hospitaliers.

5.4 Rémunération des médecins

Les ententes sur la rémunération des médecins sont négociées entre le gouvernement provincial de Terre-Neuve et du Labrador et la Newfoundland and Labrador Medical Association, avec la participation de la Newfoundland and Labrador Health Boards Association, selon des méthodes de négociation traditionnelles et officielles. Le mécanisme de règlement de différends sur lequel on s'est entendu à la suite des négociations actuelles est celui de la médiation. L'entente actuelle couvre la période allant du 1er avril 1999 au 30 septembre 2002.

Les méthodes actuelles de rémunération des médecins pour la prestation des services de santé assurés comprennent la rémunération à l'acte, à salaire et à contrat, et le financement global à la séance.

5.5 Paiements aux hôpitaux

Le ministère de la Santé et des Services communautaires a la responsabilité du financement des *Regional Health Care Boards* (conseils régionaux de santé) et des Health and Community Services Boards (conseils sur la santé et les services communautaires) pour les opérations permanentes et les achats de biens d'équipement. Le financement des services assurés est accordé aux conseils au moyen d'un budget annuel global; ces fonds annuels sont répartis en 12 paiements mensuels versés à l'avance. L'obligation de rendre des comptes des conseils comprend la nécessité de se conformer aux exigences annuelles de production de rapports du ministère, ce qui inclut des états financiers vérifiés et d'autres données financières et statistiques. Le processus est le même pour tous les conseils régionaux de santé, les conseils sur la santé et les services communautaires et les autres organismes financés par subventions de la province.

Les paiements sont faits aux conseils régionaux de santé et aux conseils sur la santé et les services communautaires conformément à la *Department of Health and Community Services Act* et à la *Hospitals Act*.

Tous les conseils régionaux de santé et les conseils sur la santé et les services communautaires fonctionnent avec un budget global à partir duquel chaque conseil répartit entre les programmes approuvés le financement accordé par la province. Le processus d'établissement du budget global accorde à tous les conseils désignés le pouvoir et la responsabilité en ce qui a trait à l'allocation budgétaire, au moment de la réalisation de leurs mandats.

Tout au long de l'exercice, les conseils de santé peuvent présenter au ministère de la Santé et des Services communautaires des demandes de financement additionnel fondées sur des changements survenus dans les programmes ou sur une augmentation de la charge de travail. Ces demandes sont examinées et, si elles sont approuvées par le ministère, financées à la fin de chaque exercice. Toutes les corrections du niveau annuel de financement, par exemple dans le cas d'augmentations de salaire négociées, de postes supplémentaires approuvés ou de changements dans les programmes, sont financées en fonction de la date d'entrée en vigueur de ces augmentations et des besoins de trésorerie de l'exercice en question.

Les conseils font continuellement face à des enjeux dans la prestation des services de soins de santé requis ainsi qu'à des demandes accrues du système de santé, alors que les coûts augmentent, que les charges de travail du personnel s'alourdissent, que les attentes des patients sont plus grandes et que les technologies de pointe exigent toujours plus de temps, de ressources et de financement. Les conseils continuent de travailler de concert avec le ministère de la Santé et des Services communautaires pour traiter de ces questions et fournir des soins de santé efficaces, efficients et de qualité.

6.0 Reconnaissance accordée aux transferts fédéraux

Le financement consenti par le gouvernement fédéral par le truchement du Transfert canadien en matière de santé et de programmes sociaux a été reconnu et consigné par le gouvernement de Terre-Neuve et du Labrador dans des communiqués de presse, dans les sites Web du gouvernement et dans divers autres documents. Pour l'exercice 2000-2001, ces documents comprenaient les suivants :

- Comptes publics de 1999-2000, volume I
- Prévisions pour 2001-2002
- Discours du budget de 2001

Ces rapports ont été déposés par le gouvernement à l'assemblée législative et sont accessibles aux résidents de Terre-Neuve et du Labrador.

7.0 Services complémentaires de santé

Le gouvernement de Terre-Neuve et du Labrador ont mis sur pied des programmes de soins de longue durée en établissement et des programmes communautaires comme solution de rechange aux services hospitaliers. Ces programmes sont assurés par sept conseils régionaux et sont décrits ci-dessous.

Services de soins infirmiers à domicile

L'hébergement de longue durée en établissement est prévu pour les clients nécessitant des soins infirmiers importants dans 18 centres de santé communautaire et 19 maisons de repos. Il y a environ 2 800 lits se trouvant dans 37 établissements. Les résidents paient un maximum de 2 800 $ par mois, en fonction de leur capacité de payer, déterminée selon les critères provinciaux d'évaluation de la situation financière. Le reste du financement requis pour faire fonctionner ces établissements est fourni par le ministère de la Santé et des Services communautaires.

Foyers de soins personnels

Les personnes ayant besoin de visites de surveillance ou d'assistance minimale dans les activités quotidiennes peuvent se prévaloir des services résidentiels offerts dans les foyers de soins personnels. Il y a environ 2 400 lits dans 103 foyers situés dans l'ensemble de la province. Ces foyers sont exploités par le secteur privé à but lucratif. Les résidents paient un maximum de 968 $ par mois, montant établi au moyen d'une évaluation de chaque client selon des critères financiers normalisés. En 2000-2001, 136 subventions de plus ont été consentis en vertu d'un plan quinquennal visant à permettre à un plus grand nombre de personnes âgées d'avoir accès à ce type de services en établissement.

Services de soins à domicile

Les services de soins à domicile comprennent les soins de soutien professionnel et non professionnel permettant aux personnes de demeurer chez elles aussi longtemps que possible sans risques. Les services professionnels comprennent les soins infirmiers et certains programmes de réadaptation. Ces services sont financés par l'État et assurés par le personnel dont les six conseils régionaux ont retenu les services.

Les services non professionnels comprennent les soins personnels, l'administration de la maison, les soins de répit et la maîtrise du comportement. Ces services sont assurés par des aides à domicile par l'entremise d'une agence ou en vertu d'ententes de soins autogérés. L'admissibilité aux services non professionnels est établie à l'aide d'une évaluation de la situation financière du client selon les critères provinciaux. Le plafond de 2000 établi pour les services de soutien à domicile est de 2 268 $ pour les personnes âgées et de 3 240 $ pour les personnes ayant une déficience physique ou accusant un retard de développement.

Programme d'aide spéciale

Le programme provincial d'aide spéciale offre des services élémentaires d'aide financière et d'aide dans les activité quotidiennes aux personnes admissibles. Ces services comprennent l'accès à des fournitures médicales, à de l'oxygène, à des orthèses et à de l'équipement.

Régime d'assurance-médicaments

Le régime d'assurance-médicaments destiné aux aînés est offert aux résidents de plus de 65 ans qui reçoivent le Supplément de revenu garanti et qui sont inscrits à la Sécurité de la vieillesse. L'assurance couvre la partie du coût des produits d'ordonnance assurés qui correspond aux ingrédients. Tous les coûts additionnels, tels que les honoraires du pharmacien, sont à la charge de l'assuré. Les prestataires du soutien du revenu sont admissibles à un régime spécial d'assurance-médicaments qui couvre le coût entier des produits d'ordonnance assurés, dont une marge sur le coût d'achat et les honoraires du pharmacien.

Autres programmes

Le ministère de la Santé et des Services communautaires administre les programmes de services ambulanciers aériens et routiers par l'intermédiaire de la Division des services de santé d'urgence. Le programme de services ambulanciers aériens fournit le transport et les soins médicaux aux patients, dans la province de Terre-Neuve et du Labrador, ainsi que vers des hôpitaux hors province, lorsque c'est justifié. Les services ambulanciers aériens transportent aussi les patients, le personnel médical et l'équipement dans les collectivités isolées de la province ou en dehors de celles-ci, au besoin. Le programme de services ambulanciers routiers fournit le transport et les soins médicaux aux résidents qui sont accessibles par voie terrestre, à un coût raisonnable pour l'utilisateur. Tant pour les services ambulanciers aériens que pour les services routiers, des frais modérateurs sont exigés.

Les donneurs de rein ainsi que les donneurs de mœlle osseuse et de cellules-souches peuvent recevoir une aide financière lorsque le receveur est un résident de Terre-Neuve et du Labrador admissible à la couverture en vertu du régime d'assurance-hospitalisation et du régime d'assurance-soins médicaux de Terre-Neuve. Les résidents qui doivent utiliser une ligne aérienne commerciale pour avoir accès à des services assurés médicalement nécessaires non disponibles dans leur région de résidence ou dans la province peuvent être admissibles à une aide financière en vertu du Medical Transportation Program (programme de transport médical).

Le régime de soins dentaires comprend une composante de soins dentaires pour les enfants et une composante d'aide sociale. Dans le premier cas, le programme couvre les services dentaires suivants pour les enfants de moins de 12 ans : examens tous les six mois, nettoyage tous les 12 mois, applications de fluorure tous les 2 mois pour les enfants de 6 à 12 ans, radiographies (certaines restrictions sont imposées), obturations et extractions, et certaines autres procédures précises qui doivent être approuvées avant le traitement. Ces services de base sont aussi offerts en vertu du programme de soutien du revenu aux assurés de 13 à 17 ans. Les adultes recevant des prestations d'aide sociale sont admissibles aux soins d'urgence et aux extractions. Les assurés couverts en vertu du régime de soins dentaires doivent verser un montant directement au dentiste pour chaque service assuré. Lorsqu'il s'agit d'un prestataire du soutien du revenu, une quote-part est versée par le régime de soins dentaires.

Île-du-Prince-Édouard

Introduction

Le ministère de la Santé et des Services sociaux est une organisation très vaste et complexe offrant des services intégrés qui visent à protéger, maintenir et améliorer la santé et le bien-être des Prince-Édouardiens.

La durabilité de l'organisation est un souci de premier plan. Au cours des dernières années, le budget consacré à la santé et aux services sociaux a augmenté rapidement pour atteindre 42 p. 100 des dépenses que le gouvernement provincial consacre à ses programmes. À ce rythme, les dépenses du Ministère pourraient atteindre 50 p. 100 de l'ensemble des dépenses gouvernementales au cours des cinq prochaines années. La disponibilité des professionnels de la santé a aussi une incidence sur notre capacité à maintenir les services.

Nous sommes préoccupés par le taux élevé de maladies chroniques dans la province, telles que maladies cardiovasculaires, cancer, diabète et maladie mentale. Les initiatives visant le bien-être aideront les Prince-Édouardiens à mieux accepter leur propre responsabilité face à leur santé de même qu'à atteindre leur pleine santé. Pour ce faire, on établira des partenariats avec la collectivité afin de promouvoir un style de vie sain et de réduire les facteurs de risque pouvant mener à la maladie chronique, de même qu'en facilitant l'accès aux services de santé de première ligne où l'on s'occupe de prévention et de traitement.

Le recrutement, la rétention et la planification des ressources humaines demeureront prioritaires afin de garantir une main-d'oeuvre adéquate et une palette appropriée de professionnels de la santé et des services sociaux afin d'être en mesure de répondre aux nouveaux besoins. La rétention du personnel sera favorisée par des programmes complets de bien-être en milieu de travail, programmes qui feront la promotion de l'excellence organisationnelle, de saines pratiques en matière d'hygiène personnelle et des milieux de travail sécuritaires.

Aperçu du système de santé et des services sociaux

L'Île-du-Prince-Édouard jouit d'un système de santé administré et financé par le gouvernement et qui garantit l'accès universel aux services hospitaliers et médicaux requis, conformément à la *Loi canadienne sur la santé*. De nombreux autres services de santé et services sociaux sont financés en tout ou en partie par le gouvernement provincial.

Le système comprend une vaste gamme de services de santé et de services sociaux intégrés comme les soins de courte durée, lutte contre les toxicomanies, la santé mentale, l'aide sociale et les services de logement. Certains services spécialisés sont accessibles par le biais du système de santé régional, par exemple, la chirurgie cardiaque et les services de neurotraumatologie.

Établissements

L'Î.-P.-É. compte deux hôpitaux de recours et cinq hôpitaux communautaires, pour un total de 474 lits. En plus de sept résidences pour personnes âgées administrées par le gouvernement et pouvant accueillir 546 personnes pour des soins de longue durée, les Prince-Édouardiens ont accès à 407 lits supplémentaires dans des foyers privés de soins infirmiers. Le système compte également plusieurs établissements de lutte contre les dépendances et de soins de santé mentale, 1 178 unités d'hébergement pour personnes âgées et 460 unités de logement familial.

Un centre provincial de lutte contre les dépendances de 40 lits et un centre provincial de traitement du cancer ont ouvert leurs portes en 2000. Un établissement de santé est en cours de construction à Summerside et sera terminé

en 2003, au coût de 50 millions de dollars. Les hôpitaux de recours offrent des services de tomographie par ordinateur et un large éventail de services d'imagerie diagnostique, et posséderont bientôt un accélérateur linéaire et l'équipement IRM.

Ressources humaines

Le secteur public des services de santé et de services sociaux repose sur une main-d'oeuvre d'environ 4 000 personnes. L'Île-du-Prince-Édouard compte 200 professionnels de la santé pour 10 000 habitants, comparativement à la moyenne nationale de 182 par 10 000 habitants[1].

Structure

Le système comprend le ministère de la Santé et des Services sociaux et cinq autorités sanitaires régionales, gouvernés par des commissions régionales. Le Ministère collabore avec les autorités sanitaires régionales pour fixer les buts et objectifs, élaborer les politiques et les normes visées, et pour attribuer les ressources. Les autorités sanitaires régionales planifient et dispensent les principaux programmes et services de manière à répondre aux normes du système.

Ressources financières

Au cours des 10 dernières années, le budget du gouvernement provincial consacré à la santé et aux services sociaux est passé de 250 millions à plus de 353 millions de dollars, soit une hausse moyenne d'environ trois pour cent par année. Cette augmentation est due à l'inflation, à la croissance de la population, aux nouvelles technologies et à une plus grande utilisation des services par tous les groupes d'âge.

Les principales dépenses en santé et services sociaux sont distribuées comme suit : services hospitaliers, 33 p. 100; services sociaux, 24 p. 100; soins de longue durée, 11 p. 100; services des médecins, 12 p. 100; autres services (programmes provinciaux de lutte contre la drogue, Programme des services infirmiers de l'hygiène publique et services de lutte contre les dépendances), 20 p. 100.

Au total, les dépenses des secteurs privé et public *per capita* sont de 2 516 $ par année, comparativement à la moyenne canadienne de 2 700 $. Les dépenses constituent 11,7 p. 100 du produit intérieur brut de la province, le deuxième taux le plus élevé au pays[2].

Questions névralgiques

Disponibilité des professionnels de la santé

Maintenir un bassin adéquat de travailleurs est l'une des difficultés auxquelles le système fait face. On s'attend à ce que le recrutement et la rétention des employés compétents constitue un défi dans l'ensemble du marché du travail au cours des prochaines années, étant donné un changement démographique majeur. Les effets de cette tendance se font d'abord sentir dans le secteur de la santé, secteur où le travail est intensif et qui repose sur une main-d'oeuvre spécialisée, et particulièrement dans les régions moins peuplées comme l'Île-du-Prince-Édouard. L'offre de professionnels de la santé diminue au fur et à mesure que la main-d'oeuvre vieillit, que le nombre de retraités augmente et que le nombre de diplômés disponibles diminue. Par exemple, on s'attend au cours des 10 prochaines années à ce que 40 p. 100 des médecins et plus de 200 infirmières de la province se retirent du secteur public. Pour faire face à ce problème, le système doit mieux se concentrer sur le bien-être en milieu de travail et sur la planification des ressources humaines afin de garantir une offre adéquate et une palette appropriée de professionnels de la santé pour répondre aux nouveaux besoins.

[1] Institut canadien d'information sur la santé, 1997.

[2] Institut canadien d'information sur la santé, 1997.

Demande et attentes du public

La demande de services augmente dans presque tous les secteurs, et ce pour diverses raisons, notamment la croissance de la population, la disponibilité de nouveaux médicaments et de nouvelles technologies, et les attentes de plus en plus élevées du public. Les gens veulent plus de médecins, plus d'infirmières, plus de médicaments, plus de technologies et plus de services familiaux. Ils veulent pouvoir accéder aux soins dans leur propre collectivité et s'inquiètent devant les listes d'attente. Bien que ces attentes à la hausse plaident pour une augmentation des dépenses consacrées aux soins de courte durée, elles limitent grandement la capacité du système à innover et transférer les ressources vers des domaines qui pourraient répondre à d'autres besoins.

Les attentes de plus en plus élevées du public face au système est une question des plus pressante. La demande seule ne suffit pas à activer le système. Le public doit être mieux informé au sujet de l'accès raisonnable et du besoin d'apporter de réels changements dans la façon de dispenser les services, particulièrement les services de santé primaires.

Accès approprié aux services de santé primaires

On reconnaît de plus en plus que les investissements dans le domaine des services de santé primaires ont une grande incidence sur la santé et sur la durabilité. Les services de santé primaires sont ceux auxquels les gens accèdent en premier lieu et le plus souvent, comme les services des médecins de famille, ceux des infirmières en santé publique, les programmes de dépistage, les services de lutte contre les dépendances et les services communautaires de santé mentale.

Pratiques personnelles en matière de santé

Ceux qui comprennent et acceptent leur propre responsabilité en ce qui concerne leur santé sont plus en mesure de contrôler et d'améliorer leur santé.

La capacité des gens à accepter leur propre responsabilité dans ce domaine est influencée par des conditions sociales et économiques; il faut donc définir des stratégies complètes pour favoriser ces conditions. Il est de prime importance que le système de santé ait une meilleure capacité à collaborer avec d'autres pour aider les individus, les familles et les collectivités à accepter la responsabilité qui est la leur pour atteindre une bonne santé.

Population vieillissante

Durant les trois prochaines décennies, avec le vieillissement des baby boomers, nous connaîtrons le plus important changement démographique de notre histoire. On s'attend à ce que la proportion de la population de l'Île-du-Prince-Édouard âgée de 65 ans et plus passe de 13 p. 100 aujourd'hui à 15 p. 100 en 2011, et à 27 p. 100 en 2036. Cela aura diverses répercussions sur le système de santé. On s'attend à ce que l'incidence de maladies comme le cancer, les maladies coronariennes, le diabète et la démence augmente. La demande devrait aussi être à la hausse pour les soins de courte durée, les soins de longue durée, les soins à domicile, les soins de santé mentale et autres services. Ce problème prend encore plus d'ampleur lorsqu'on considère que la main-d'oeuvre dans le domaine de la santé vieillit aussi. Les membres de la famille seront moins nombreux pour aider leurs parents âgés, et la quantité des ressources requises pour maintenir les services pour les personnes âgées pourrait avoir des répercussions négatives sur d'autres services gouvernementaux touchant la santé. Il est essentiel que le système de santé soit prêt à répondre à ces nouveaux besoins.

Prévention et traitement de la maladie

De nombreuses maladies sont évitables. La méningite, par exemple, peut être prévenue par un vaccin, et la propagation des maladies transmissibles sexuellement peut être évitée grâce à un comportement responsable. On peut aussi éviter plusieur nombre de maladies chroniques. Les facteurs de risques de la maladie coronarienne et du cancer peuvent être réduits, ou éliminés, grâce à l'éducation et le soutien en vue d'un changement de mode de vie.

Selon l'Organisation mondiale de la Santé, le diabète prend une proportion d'épidémie partout dans le monde. À l'Île-du-Prince-Édouard, de 17 nouveaux cas qui étaient diagnostiqués tous les mois au milieu des années 1970, on est passé à 45 cas par mois au milieu des années 90. On s'attend à ce que ce nombre passe à 65 en 2006. On sait de façon claire et irréfutable que le fait de contrôler sa glycémie peut aider à prévenir ou à retarder l'apparition de graves complications du diabète, comme la maladie coronarienne, la cécité et la maladie des reins, lesquelles engendrent d'énormes coûts humains et financiers. La prévalence du cancer et du diabète dans la province devrait augmenter de manière marquée avec le vieillissement de la population. Il est essentiel que notre système intensifie ses efforts pour aider les Prince-Édouardiens à prévenir, retarder et traiter ces conditions.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le régime d'assurance-hospitalisation, placé sous l'autorité du ministre de la Santé et des Services sociaux, est le moyen de prestation de l'assurance-hospitalisation dans l'Île-du-Prince-Édouard. Il est autorisé en vertu de la *Hospital and Diagnostic Services Insurance Act* (1988), qui prévoit l'assurance des services, comme il est indiqué dans l'article 2 de la *Loi canadienne sur la santé*.

La partie I de la Loi stipule que le ministre exerce l'autorité et détient les pouvoirs suivants :

- assurer la mise en valeur et le maintien d'un réseau équilibré et intégré d'hôpitaux, d'écoles d'infirmières et établissements de santé connexes dans toute la province;
- approuver ou refuser l'établissement de nouveaux hôpitaux et établissements de santé connexes ou l'expansion de ces derniers;
- approuver ou désapprouver toute subvention à la construction ou à l'entretien d'établissements hospitaliers;
- établir et administrer, seul ou en collaboration avec un ou plusieurs organismes, des instituts de formation pour le personnel hospitalier et le personnel connexe;
- mener des enquêtes et diriger des programmes de recherche en vue d'obtenir des données statistiques à ces fins;
- approuver ou rejeter des hôpitaux ou d'autres installations aux fins de la Loi, conformément aux règlements;
- sur approbation du lieutenant gouverneur en conseil, prendre toute autre mesure que le ministre juge nécessaire ou utile pour traduire efficacement l'intention et les visées de la Loi.

Outre les responsabilités et pouvoirs énumérés dans la partie I de la Loi, le ministre exerce l'autorité et détient les pouvoirs suivants :

- administrer le régime d'assurance-hospitalisation établi par la Loi et les règlements;
- déterminer les sommes à verser aux hôpitaux et défrayer ceux-ci pour les services assurés fournis aux personnes assurées en vertu du régime d'assurance-hospitalisation; faire des rajustements rétroactifs avec les hôpitaux pour les sommes impayées ou versées en trop pour des services assurés, selon les coûts déterminés conformément à la Loi et aux règlements;
- percevoir ou débourser toutes les sommes afférentes au régime d'assurance-hospitalisation;
- approuver ou refuser les frais imposés aux patients par les hôpitaux de l'Île-du-Prince-Édouard qui reçoivent des paiements dans le cadre du régime d'assurance-hospitalisation;
- conclure des accords avec des hôpitaux situés à l'extérieur de l'Île-du-Prince-Édouard, avec d'autres gouvernements et avec les autorités responsables du régime d'assurance-hospitalisation établies par d'autres gouvernements pour fournir des services assurés aux personnes assurées;

- prescrire les formulaires nécessaires et souhaitables pour traduire l'intention et les visées de la Loi;
- désigner des inspecteurs et d'autres représentants officiels ayant la responsabilité et le pouvoir d'obtenir et d'examiner l'information contenue dans les registres comptables des hôpitaux, les livres, les rendus, les rapports et les états financiers vérifiés et d'en faire rapport;
- désigner des médecins praticiens ayant la responsabilité et le pouvoir d'obtenir et d'examiner l'information contenue dans les dossiers médicaux et les autres dossiers tenus par les hôpitaux, y compris les dossiers des patients, incluant leur dossier médical et les notes rédigées par les infirmières, les rapports et les relevés de compte de patients qui reçoivent ou ont reçu des services assurés;
- désigner des inspecteurs ayant la responsabilité et le pouvoir d'inspecter et d'examiner les livres, les relevés de compte et les dossiers des employeurs et des percepteurs dans le but d'obtenir de l'information relative aux hôpitaux et au régime d'assurance;
- retenir le paiement des services assurés pour toute personne assurée dont, selon le ministre, l'état de santé ne nécessitait pas de tels services;
- agir comme premier responsable des achats pour les achats de médicaments, de préparations biologiques ou de préparations connexes de tous les hôpitaux de la province pour superviser, vérifier et inspecter l'utilisation des médicaments, des préparations biologiques et des préparations connexes par les hôpitaux de la province et pour retenir ou réduire les sommes versées, en vertu de la Loi, à un hôpital qui ne respecte pas les règlements relatifs à l'achat de médicaments, de préparations biologiques et de préparations connexes;
- superviser et assurer l'utilisation efficace et économique de toute aide ou procédure diagnostique ou thérapeutique utilisée par ou dans les hôpitaux, et retenir ou réduire les sommes versées, en vertu de la Loi, à un hôpital qui ne respecte pas les règlements relatifs à l'utilisation de ces aides et procédures.

Le ministre de la Santé, par l'intermédiaire du ministère de la Santé et des Services sociaux, a la responsabilité de l'efficience et de l'efficacité globales du système de santé provincial. Le Ministère est notamment responsable :

- d'établir des orientations et des priorités générales;
- d'élaborer des politiques et des stratégies, des lois, des normes et des mesures provinciales;
- de surveiller l'état de santé dans la province;
- de surveiller les cinq autorités sanitaires régionales et de s'assurer que celles-ci respectent les règlements et se conforment aux normes;
- d'évaluer le rendement du système de santé;
- d'allouer des fonds aux cinq autorités sanitaires régionales;
- d'améliorer la qualité et la gestion d'un système d'information sur la santé complet à l'échelle de la province;
- de garantir l'accès à des services de santé de haute qualité;
- de régler les questions émergentes sur la santé et d'examiner les nouvelles technologies avant de les appliquer;
- d'administrer directement certains services et programmes.

Les cinq autorités sanitaires régionales sont responsables de la prestation des services conformément à la *Health and Community Services Act* (1993). Elles administrent les hôpitaux, les centres de santé, les résidences pour personnes âgées et les établissements psychiatriques et recrutent les médecins, les infirmières et les autres travailleurs de la santé. Elles ont la responsabilité :

- d'évaluer les besoins en santé des résidents dans leur région;
- d'informer et de conseiller les résidents;
- d'allouer et de gérer les ressources pour les priorités établies, de recruter le personnel et de tirer la meilleure partie des ressources disponibles;

- de consulter d'autres organismes oeuvrant dans le domaine de la santé;
- d'élaborer des politiques, des normes et des mesures;
- de planifier et de coordonner, avec le Ministère et d'autres autorités, la prestation d'une gamme complète de services de santé;
- de promouvoir la santé et le bien-être dans leur communauté;
- de rendre disponible l'information sur les choix concernant la santé et les services de santé pour les résidents;
- d'assurer un accès raisonnable aux services de santé;
- de surveiller et d'évaluer le rendement et d'en faire rapport aux résidents et au Ministère.

1.2 Liens hiérarchiques

Le ministère de la Santé et des Services sociaux présente un rapport annuel au ministre responsable, qui le dépose devant l'Assemblée législative. Le rapport annuel fournit de l'information sur les principes directeurs du Ministère et sur ses responsabilités législatives, donne une vue d'ensemble et une description des activités des divisions du Ministère et met en relief les principales statistiques de l'année.

La Loi stipule que chacune des cinq autorités sanitaires régionales doit soumettre un rapport annuel au ministre de la Santé et des Services sociaux. Ce dernier peut demander toute autre information jugée nécessaire sur les activités des autorités et sur la prestation des services de santé dans leurs zones de responsabilité. Les autorités sanitaires régionales doivent tenir des réunions publiques annuelles et y présenter de l'information sur leurs activités et la prestation des services de santé.

1.3 Vérification des comptes

Le vérificateur général de la province effectue des vérifications annuelles des comptes publics de la province de l'Île-du-Prince-Édouard. Ces comptes comprennent les activités financières, les revenus et les dépenses du ministère de la Santé et des Services sociaux.

Chaque autorité sanitaire régionale a la responsabilité d'engager son propre cabinet d'experts-comptables pour vérifier annuellement ses états financiers. Les états financiers vérifiés sont soumis au ministre et au ministère du Trésor provincial. Les rapports sont présentés aux réunions publiques tenues annuellement dans chaque région. Les états vérifiés sont également présentés devant l'Assemblée législative et inclus dans les comptes publics publiés de la province de l'Île-du-Prince-Édouard.

En vertu de *l'Audit Act*, le vérificateur général provincial a le pouvoir discrétionnaire d'effectuer des vérifications supplémentaires touchant l'ensemble des activités ou des programmes précis menés par le ministère de la Santé et des Services sociaux et par chacune des cinq autorités sanitaires régionales.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les services hospitaliers assurés sont fournis en vertu de la *Hospital and Diagnostic Services Insurance Act* (1988). Les règlements qui accompagnent cette loi (1996) définissent les services aux patients hospitalisés et les services ambulatoires assurés qui sont disponibles sans frais aux personnes admissibles. Les services hospitaliers assurés comprennent les suivants :

- les services de soins infirmiers nécessaires;
- les services de laboratoire;
- les procédures de radiologie et les autres procédures diagnostiques;
- les frais d'hébergement et de repas au tarif d'une chambre ordinaire;
- préparations médicamenteuses, biologiques et les préparations connexes prescrites par un médecin traitant et administrées à l'hôpital;
- les salles d'opération, les chambres d'attente et les installations d'anesthésie;

- les fournitures chirurgicales courantes;
- les services de radiothérapie et de physiothérapie fournis à l'hôpital.

Depuis mars 2001, sept établissements de soins de courte durée participent au régime d'assurance de la province. Outre les 454 lits pour soins de courte durée, ces établissements comptent 20 lits pour soins de réadaptation, 19 lits pour des chirurgies d'un jour telles que définies dans la *Hospitals Act* (1998) et sept lits pour soins de longue durée assurés. Un établissement supplémentaire, le *Prince Edward Home*, compte 50 lits pour soins de longue durée assurés. De plus, l'Île-du-Prince-Édouard utilise l'équivalent de 60 lits pour soins de courte durée à l'extérieur de la province.

2.2 Services médicaux assurés

La loi habilitante qui prévoit la prestation de services de médecin assurés est la *Health Services Payment Act* (1988). Elle a été modifiée en 1996 pour inclure le processus de planification des ressources médicales.

Les services médicaux assurés sont fournis par des médecins praticiens qui sont autorisés par le Collège des médecins et chirurgiens. Il y a 215 praticiens qui ont facturé le régime d'assurance au 31 mars 2000.

En vertu de l'article 10 de la *Health Services Payment Act*, un médecin ou un praticien qui ne participe pas au régime d'assurance ne peut facturer le régime pour les services rendus. Lorsqu'un médecin ou un praticien non participant dispense un service requis sur le plan médical, le paragraphe 10(2) exige qu'il informe le patient qu'il ne participe pas au régime d'assurance et qu'il lui fournisse toute l'information nécessaire pour lui permettre de recouvrer le coût des services rendus auprès du ministre de la Santé.

En vertu du paragraphe 10.1 de la *Health Services Payment Act*, un médecin ou un praticien participant peut choisir, selon que les règlements le permettent, de percevoir des frais à l'extérieur du régime pour un patient particulier ou un service de santé de base particulier. Les patients doivent être informés avant de recevoir le service qu'ils seront facturés directement pour le service rendu. Lorsqu'un médecin ou un praticien fait ce choix, il doit en informer le ministre. La totalité des frais est ensuite exigée du patient pour le service rendu.

Au 31 mars 2001, aucun médecin n'avait choisi de se retirer du régime d'assurance.

Tout service de santé de base rendu par un médecin et nécessaire sur le plan médical est couvert par le régime d'assurance-santé. Ces services comprennent les suivants :

- la plupart des services rendus par les médecins à leur bureau, à l'hôpital ou au domicile du patient;
- les services chirurgicaux nécessaires sur le plan médical, incluant les services d'anesthésistes ou d'infirmières en chirurgie, lorsque nécessaire;
- les services obstétricaux, incluant les soins prénatals et postnatals, les soins aux nouveau-nés et les soins exigés par toute complication à la grossesse telle qu'une fausse couche ou une césarienne;
- certaines procédures de chirurgie buccale nécessaires sur le plan médical et pratiquées, à l'hôpital, par un chirurgien stomatologiste;
- les procédures de stérilisation, pour les femmes et pour les hommes;
- le traitement des fractures et des dislocations;
- certains services de spécialistes assurés, lorsque le patient a été adéquatement aiguillé par un médecin traitant.

En 2000-2001, aucun service n'a été ajouté à la liste des services médicaux assurés.

Un service médical peut être ajouté à la liste des services assurés à la suite d'une négociation entre le ministère de la Santé et des Services sociaux et la *Société médicale de l'Île-du-Prince-Édouard*.

2.3 Services de chirurgie dentaire assurés

Les services dentaires ne sont pas couverts par le régime. Seuls les spécialistes en chirurgie maxillo-faciale sont remboursés par le régime. Cette catégorie comporte actuellement deux chirurgiens. Les procédures chirurgicales dentaires comprises comme services de santé de base dans le tarif des honoraires sont couvertes uniquement lorsque le médecin traitant confirme que la condition médicale du patient nécessite une intervention à l'hôpital.

Un service chirurgical dentaire peut être ajouté à la suite d'une négociation entre la *Dental Association of Prince Edward Island* et le ministère de la Santé et des Services sociaux

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Les services hospitaliers provinciaux non couverts par le *Hospital Services Plan* comprennent :

- les services auxquels les patients sont admissibles en vertu d'autres lois fédérales ou provinciales;
- les frais d'essence ou de déplacement, à moins qu'ils ne soient approuvés par le Ministère;
- les conseils ou les prescriptions par téléphone, à l'exception de la supervision de l'anticoagulothérapie;
- les examens requis pour le travail, les assurances, les études, etc.;
- les examens, les vaccinations ou les inoculations en groupe, à moins d'une approbation préalable par le Ministère;
- la préparation de dossiers, de rapports, de certificats ou de communications, à l'exception des certificats d'internement dans un établissement psychiatrique ou de désintoxication (drogues ou alcool);
- les témoignages en cour;
- les chirurgies à caractère esthétique, à moins qu'elles ne soient nécessaires sur le plan médical;
- les services dentaires autres que les procédures comprises dans les services de santé de base;
- les pansements, les médicaments, les vaccins, le matériel biologique et le matériel connexe;
- les lunettes et les appareils spéciaux;
- la physiothérapie, la chiropraxie, la podologie, l'optométrie, l'ostéopathie, la psychologie, la naturopathie, l'audiologie, l'acupuncture et les traitements similaires;
- le rétablissement de la fertilité;
- la fertilisation *in vitro*;
- les services rendus par une autre personne lorsque le médecin superviseur est absent ou non disponible;
- les services rendus par un médecin à des membres de sa famille, à moins d'une approbation du Ministère;
- tout autre service que le Ministère peut, sur recommandation du comité médical consultatif, déclarer non assuré.

Les services hospitaliers provinciaux non couverts par le *Hospital Services Plan* comprennent les soins infirmiers privés ou spéciaux dispensés à la demande du patient ou de sa famille; les chambres à suppléments, à la demande du patient; les services hospitaliers rendus dans le cadre d'une chirurgie purement esthétique; appareils pour usage personnel comme le téléphone et la télévision; les médicaments, produits biologiques, prothèses et orthèses utilisées après avoir obtenu le congé de l'hôpital; les extractions dentaires, sauf dans les cas où le patient doit être admis à l'hôpital pour des raisons médicales, avec l'approbation préalable du ministère de la Santé et des Services sociaux.

La suppression d'un service du régime d'assurance-santé s'effectue en collaboration avec la *Medical Society of Prince Edward Island* et le ministère de la Santé et des Services sociaux.

3.0 Universalité

3.1 Admissibilité au régime

L'article 3 de la *Health Services Payment Act and Regulations* définit l'admissibilité aux régimes d'assurance-santé. Les régimes sont conçus pour offrir une couverture aux résidents admissibles de l'Île-du-Prince-Édouard (c'est-à-dire quiconque est légalement autorisé à demeurer au Canada et est ordinairement présent, dans sa résidence de l'Île-du-Prince-Édouard, au moins six mois plus un jour par année).

Tous les nouveaux résidents doivent s'inscrire auprès du Ministère pour devenir admissibles. Les personnes de l'extérieur de la province qui établissent une résidence permanente dans l'Île-du-Prince-Édouard deviennent admissibles aux services médicaux et hospitaliers assurés le premier jour du troisième mois suivant le mois de leur arrivée.

Les résidents qui ne sont pas admissibles à la couverture du régime d'assurance-santé de l'Île-du-Prince-Édouard sont les membres des Forces canadiennes (FC), les membres de la Gendarmerie royale du Canada (GRC), les détenus dans un pénitencier fédéral et les personnes admissibles à certains services en raison de programmes d'autres gouvernements tels que l'Indemnisation des travailleurs ou les programmes du ministère des Anciens Combattants.

Les résidents inadmissibles peuvent devenir admissibles dans les cas suivants : membres des FC ou de la GRC, détenus de pénitenciers élargis, libérés ou libérés à la suite d'un congé de réadaptation lorsque ce dernier est financé par les FC, la province où la personne était incarcérée ou engagée au moment de l'élargissement ou de la libération, ou la province de résidence au moment de la terminaison du congé de réadaptation, selon le cas, fournira la couverture initiale pour la période d'attente habituelle qui peut aller jusqu'à trois mois. Les détenus de pénitenciers en liberté conditionnelle seront traités de la même manière que les détenus élargis.

Les étudiants étrangers, les touristes, les personnes de passage et les visiteurs de l'Île-du-Prince-Édouard ne peuvent être reconnus comme résidents de la province et, de ce fait, ne sont pas admissibles aux avantages offerts par l'assurance des soins hospitaliers et médicaux.

3.2 Exigences relatives à l'inscription au régime

Les nouveaux résidents et les résidents de retour doivent s'inscrire au régime d'assurance-santé en remplissant un formulaire d'inscription auprès du Ministère. La demande est examinée pour s'assurer que toute l'information nécessaire est fournie. Une carte santé est délivrée et envoyée au résident dans un délai de deux semaines. Le renouvellement de l'assurance a lieu tous les cinq ans, et les résidents en sont avisés, par écrit, six semaines avant le renouvellement.

Il y avait 138 205 résidents inscrits au régime d'assurance-santé de l'Île-du-Prince-Édouard au 31 mars 2001.

3.3 Autres catégories de personnes

Les étudiants étrangers, les travailleurs temporaires, les réfugiés et les détenteurs de permis ministériel ne sont pas admissibles à l'assurance-santé et à la couverture des soins médicaux. Les réfugiés du Kosovo constituent une exception à cette catégorie et sont admissibles à l'assurance-santé et à la couverture des soins médicaux dans l'Île-du-Prince-Édouard. Le 31 mars 2001, cinquante-huit réfugiés du Kosovo étaient inscrits au régime d'assurance-santé.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes assurées qui déménagent dans l'Île-du-Prince-Édouard sont admissibles à l'assurance-santé le premier jour du troisième mois suivant le mois de leur arrivée dans la province.

4.2 Couverture durant des absences temporaires (au Canada)

Les personnes qui s'absentent chaque année pour des vacances d'hiver ou des situations semblables nécessitant des absences régulières doivent résider dans l'Île-du-Prince-Édouard au moins six mois plus un jour chaque année pour être admissibles à l'assurance en cas de maladie subite ou de situation d'urgence survenant à l'extérieur de la province, conformément à l'alinéa 5.1.(e) de la *Health Services Payment Act*.

Le terme « absence temporaire » est défini comme une période d'absence de la province pouvant aller jusqu'à 182 jours dans une période de 12 mois pour des raisons de vacances, de visite ou d'engagement professionnel. Les personnes quittant la province dans les circonstances mentionnées ci-dessus doivent s'inscrire auprès du Ministère avant leur départ.

L'Île-du-Prince-Édouard participe aux ententes de facturation réciproque pour les services médicaux et hospitaliers.

Le tarif est de 576 $ par jour pour un séjour à l'hôpital. Le tarif inter-provincial courant pour un service ambulatoire est de 110 $. La méthode utilisée pour calculer ces tarifs est fondée sur le coût du même service s'il était rendu dans l'Île-du-Prince-Édouard.

4.3 Couverture durant des absences temporaires (à l'étranger)

La *Health Services Payment Act* est la loi habilitante qui définit la transférabilité de l'assurance-santé durant des absences temporaires à l'étranger, conformément à l'alinéa 5.1.(e) de la *Health Services Payment Act*.

Les résidents assurés peuvent séjourner temporairement à l'extérieur du pays pour une période de 12 mois et ce, une fois seulement. Les étudiants qui fréquentent un établissement d'enseignement agréé dans un autre pays doivent fournir annuellement une preuve de leur inscription délivrée par cet établissement. Les étudiants doivent aviser le Ministère à leur retour au pays.

Pour les résidents de l'Île-du-Prince-Édouard qui quittent le pays pour des raisons professionnelles pour une période de plus d'un an, la couverture se termine le jour du départ de la personne.

Pour les résidents qui voyagent à l'extérieur du Canada, la couverture en cas de situation d'urgence ou de maladie subite sera fournie au taux de l'Île-du-Prince-Édouard uniquement, en devise canadienne. Il incombe aux résidents de payer la différence entre le montant total facturé et le montant déboursé par le Ministère.

Les sommes versées pour des services d'urgence assurés reçus à l'étranger totalisaient 75 500 $ en 2000-2001.

4.4 Nécessité d'une approbation préalable

Une approbation préalable du Ministère est nécessaire pour recevoir des services médicaux ou hospitaliers non urgents à l'extérieur de la province. Les résidents de l'Île-du-Prince-Édouard qui veulent recevoir ces services peuvent demander une approbation préalable par l'intermédiaire d'un médecin de l'Île-du-Prince-Édouard. Une couverture complète peut être assurée pour les services urgents et non urgents (assurés dans l'Île-du-Prince-Édouard) si le médecin en a fait la demande auprès du Ministère. Une approbation préalable du directeur médical du ministère de la Santé et des Services sociaux est nécessaire pour recevoir, à l'étranger, des services hospitaliers ou médicaux non disponibles au Canada.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Les régimes d'assurance-santé et d'assurance-hospitalisation de l'Île-du-Prince-Édouard permettent de recevoir des services selon des modalités et des conditions uniformes pourvu qu'ils n'entravent pas ou n'empêchent pas un accès raisonnable à ces services pour les personnes assurées.

5.2 Accès aux services hospitaliers assurés

Les sept établissements de soins de courte durée de l'Île-du-Prince-Édouard comptent un nombre total de 474 lits approuvés (454 lits pour soins de courte durée plus 20 lits pour soins de réadaptation). Seize lits pour soins de courte durée supplémentaires sont réservés aux services hospitaliers assurés dans un établissement psychiatrique. Il n'existe pas de données relatives à l'admission pour ces 16 lits. Durant l'exercice 2000-2001, il y a eu, en tout, 18 340 admissions. Le nombre de jours d'occupation des lits pour soins de courte durée des hôpitaux de l'Île-du-Prince-Édouard atteignait 142 302 (en excluant les nouveau-nés), et la durée de séjour moyenne était de 7,8 jours. À cause de changements apportés au système, on ne dispose pas en 2000-2001 de données sur les soins hospitaliers assurés dispensés à l'extérieur de la province. On ne dispose d'aucune donnée sur le nombre d'admissions, la durée du séjour et le nombre de jours d'occupation des lits pour soins de longue durée.

Accélérateur linéaire

En avril 2000, le gouvernement a annoncé des projets visant à élargir la gamme de services offerts par le PEI Cancer Treatment Centre, grâce à l'ajout d'un accélérateur linéaire. On achève présentement une étude des répercussions et un plan fonctionnel à propos des services élargis de traitement du cancer. Ces services élargis devraient être opérationnels à la fin de 2002.

Imagerie par résonnance magnétique (IRM)

En avril 2000, le gouvernement a annoncé l'expansion des services d'imagerie diagnostique pour les résidents grâce à l'achat d'une unité IRM pour le Queen Elizabeth Hospital. On a mis sur pied un comité chargé de superviser la phase de planification des services IRM, qui devraient être opérationnels à la fin de 2002. L'étude des répercussions est terminée et on achève le plan fonctionnel.

Services ambulanciers

Les modifications apportées à la *Public Health Act* concernant les services médicaux d'urgence et les règlements afférents ont été approuvés pour la proclamation le 1er janvier 2001. Cette loi prévoit des améliorations à l'administration et à la prestation des services médicaux d'urgence.

En avril 2000, le gouvernement a annoncé la création d'un programme de soutien au transport pour recevoir des soins médicaux à l'extérieur de la province (Out of Province Medical Transport Support Program), programme destiné à couvrir une partie du coût du transport en ambulance à l'extérieur de la province. Ce programme permet de réduire les frais que les résidents admissibles doivent payer lorsqu'ils doivent recevoir des soins médicaux spécialisés à l'extérieur de la province.

Accessibilité : Nouvelles initiatives

La stratégie de recrutement des infirmières, annoncées dans le cadre du budget provincial 2000, en est à sa deuxième année. Toutes les stratégies ont été mises en oeuvre dans la province. Bien que la stratégie vise tous les secteurs des soins de santé, on accorde la priorité au secteur institutionnel, soit les soins de courte durée et les soins de longue durée. Le Ministère procède actuellement à l'élaboration d'un cadre d'évaluation qui servira à évaluer officiellement les résultats obtenus.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Les services de médecin sont accessibles dans toute la province, sauf pour les spécialités où il existe des postes à pourvoir. On a entrepris de recruter des médecins de famille, un oto-rhino-laryngologiste, des psychiatres, un radiologiste et un obstétricien. Une stratégie de recrutement a été annoncée et prévoit des incitatifs pour les nouveaux diplômés et les nouvelles recrues, ainsi qu'une augmentation du nombre de places réservées aux résidents de l'Île-du-Prince-Édouard dans des écoles de médecine situées à l'extérieur de la province.

5.4 Rémunération des médecins

On se sert d'un processus de négociation collective pour déterminer la rémunération des médecins. Les équipes de négociation sont nommées par les deux parties, les médecins et le gouvernement, afin de représenter les intérêts respectifs au cours du processus. Une nouvelle convention triennale a été négociée et expirera le 31 mars 2004.

La loi qui régit le paiement des médecins et des dentistes pour des services assurés est la *Health Services Payment Act*.

La plupart des médecins travaillent suivant la formule de la rémunération à l'acte. Des plans de paiement de rechange ont toutefois été élaborés, et certains médecins reçoivent des salaires, des rémunérations à contrat et des rémunérations à la vacation.

5.5 Paiements aux hôpitaux

Les autorités sanitaires régionales sont responsables de la prestation des services hospitaliers dans la province, conformément à la *Health and Community Services Act*. Les besoins financiers (budgétaires) sont établis annuellement par consultation avec le ministère de la Santé et des Services sociaux et soumis à l'approbation de l'Assemblée législative au cours du processus budgétaire annuel.

Les paiements (avances) effectués aux autorités sanitaires régionales pour les services hospitaliers sont approuvés par le Ministère en fonction des besoins de trésorerie et sont tributaires des montants approuvés au budget.

La méthode de financement normale consiste à recourir à un budget global ajusté annuellement pour tenir compte des coûts croissants associés à certains facteurs tels que les conventions collectives et les coûts des médicaments, des fournitures médicales et de l'exploitation des établissements.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement de l'Île-du-Prince-Édouard reconnaît la contribution du gouvernement fédéral fournie par le biais du Transfert canadien en matière de santé et de programmes sociaux dans son budget 2000-2001 et les documents budgétaires connexes, de même que dans les comptes publics 2000-2001, déposés devant l'Assemblée législative et mis publiquement à la disposition des résidents de l'Île-du-Prince-Édouard.

7.0 Services complémentaires de santé

Les services de soins complémentaires ne sont pas assurés, à l'exception des services fournis pour les lits de malades chroniques assurés en vertu de l'article 2.1. Les services de soins complémentaires sont fournis par l'intermédiaire des cinq autorités sanitaires régionales du système de la santé et des services sociaux. Des soins en maison de repos sont disponibles lorsque les comités d'admission et de placement régionaux autorisent le placement dans les résidences pour personnes âgées du gouvernement et les maisons de repos privées autorisées. On utilise l'outil d'évaluation des services normalisé pour déterminer les besoins en services des résidents pour toutes les admissions aux maisons de repos. La province compte 18 maisons de repos privées et

gouvernementales qui totalisent 953 lits, incluant des lits réservés aux soins de relève. La province octroie des sommes à 71 p. 100 des résidents des maisons de repos en vertu de la partie 2 des *Welfare Assistance Act Regulations*. Le gouvernement fédéral octroie des sommes à environ 8 p. 100 des résidents et les 21 p. 100 des résidents restants paient eux-mêmes les services qu'ils reçoivent. Les maisons de repos de l'Île-du-Prince-Édouard dispensent des soins de niveaux 4 et 5.

Outre les maisons de repos, l'Île-du-Prince-Édouard compte 31 établissements de soins communautaires autorisés. Au 31 mars 2001, il y avait 871 lits, en tout, dans les établissements de soins communautaires. Les 31 p. 100 des résidents qui reçoivent des sommes du gouvernement font l'objet d'une évaluation financière en vertu de la partie 1 de la *Welfare Assistance Act*. Les 69 p. 100 restants paient eux-mêmes les services qu'ils reçoivent. Les établissements de soins communautaires dispensent des soins de niveaux 1 à 3.

Les services de soutien et de soins à domicile, également non assurés, constituent un autre aspect des soins complémentaires. Les services de soutien comprennent les soins infirmiers à domicile, les auxiliaires familiales, le soutien communautaire, la protection des adultes et les soutiens professionnels et de physiothérapie. On utilise l'outil d'évaluation des personnes âgées pour déterminer la nature et le type de service nécessaire. Les services professionnels à domicile sont actuellement fournis gratuitement au client, mais sont assujetties à un plafond budgétaire. Les services des auxiliaires familiales font l'objet d'une tarification décroissante selon l'évaluation du revenu d'une personne. La demande pour les soins à domicile continue d'augmenter dans la province.

Nouvelle-Écosse

Aperçu

Au cours de 2000-2001, la Nouvelle-Écosse a accompli des progrès relativement à la réalisation de son objectif d'établir un système de soins de santé abordable, de haute qualité et viable. Ce changement était surtout axé sur l'adoption de la *Health Authorities Act*, qui est entrée en vigueur le 1er janvier 2001, afin d'établir neuf autorités sanitaires de district (ASD) qui seraient chargées de la gestion de la prestation quotidienne des services de santé.

Cette nouvelle loi permet de prévoir une plus grande responsabilisation financière. Les ASD seront tenues de fournir au ministre de la Santé des états financiers mensuels et trimestriels ainsi que des états financiers vérifiés de fin d'année. Les rapports annuels exigés fourniront des mises à jour sur la mise en œuvre des plans d'activités des ASD. Les articles de la *Health Authorities Act* reliés aux rapports financiers et à la planification des activités sont entrés en vigueur le 1er avril 2001.

De plus, un processus de planification des services cliniques a été amorcé afin de prévoir les modifications requises au système pour assurer que les Néo-Écossais, peu importe où ils habitent, reçoivent des services de santé de santé fiables, de haute qualité et viables. Les résultats de ce processus de planification ont été diffusés et partagés avec les neufs ASD en février 2001 dans un document intitulé *Making Better Health Care Decisions for Nova Scotia*.

Au cours de cette période continue de changement, la Nouvelle-Écosse est demeurée engagée à assurer la prestation de services jugés médicalement nécessaires qui sont conformes aux principes de la *Loi canadienne sur la santé*.

Des renseignements additionnels sur les soins de santé en Nouvelle-Écosse sont disponibles sur le site Web du ministère de la Santé à

www.gov.ns.ca/health

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

En Nouvelle-Écosse, deux régimes couvrent les services de santé assurés : le régime d'assurance-hospitalisation et le *Medical Services Insurance Plan* (MSI). Le régime d'assurance-hospitalisation est géré par le ministère de la Santé en vertu de la *Health Services and Insurance Act*, chapitre 197, *Revised Statutes of Nova Scotia*, 1989, articles 3(1), 5, 6, 10, 15, 16, 17(1), 18 et 35 (la Loi), laquelle a été adoptée par l'autorité législative en 1958.

Le régime MSI est administré et géré en vertu de la loi susmentionnée (articles 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32, 35) par une autorité sans but lucratif formée du ministère de la Santé et de la *Maritime Medical Care Incorporated*.

L'article 3 de la *Health Services and Insurance Act* stipule, sous réserve des dispositions de la Loi et de ses règlements, que tous les résidents de la province ont droit de recevoir des services hospitaliers assurés, selon des modalités uniformes, et que tous les résidents de la province sont assurés, selon des modalités uniformes, du paiement des coûts des services professionnels assurés et ce, jusqu'au tarif établi. En vertu de l'article 8 de la Loi, le ministre de la Santé peut, à l'occasion, avec l'approbation du gouverneur en conseil, conclure, modifier ou résilier, avec une ou des personnes, les ententes qu'il juge nécessaires à l'établissement et la réalisation du régime MSI.

En vertu du protocole d'entente de 1992, la *Maritime Medical Care Incorporated* (MMC) est autorisée à :

- déterminer l'admissibilité des fournisseurs qui participent au régime;
- planifier et à dispenser des programmes d'information et d'éducation pour s'assurer que l'ensemble des personnes et des

fournisseurs connaissent leurs droits et leurs responsabilités en vertu du régime;

- effectuer des paiements, en vertu du régime, pour toute réclamation ou catégorie de réclamations dans le cas de services de santé assurés que la province est tenue de payer;
- élaborer un système de vérification et d'évaluation des réclamations et des paiements pour assurer un processus de vérification continu et établir des structures administratives nécessaires à l'acquittement de son mandat.

1.2 Liens hiérarchiques

La MMC doit remettre à la province, au plus tard le vingtième jour de chaque mois, des rapports de dépenses sous la forme établie par celle-ci comprenant les détails demandés. Dans les trente jours précédant la fin du trimestre d'exercice, la MMC est tenue de présenter un rapport qui comprend les dépenses prévues jusqu'à la fin du trimestre ainsi qu'une prévision des dépenses jusqu'à la fin de l'exercice. Elle doit en outre présenter des procès-verbaux et des renseignements pour que la province reste au fait de toutes les réunions, les conférences, etc. qui s'inscrivent dans le cadre de l'application du régime MSI. Les rapports préparés par la MMC sont envoyés directement à la *Insured Programs Branch* du ministère de la Santé, aux fins d'examen et de suivi.

Le sous-alinéa 17(1)(i) de la *Health Services and Insurance Act* et les paragraphes 11(1) et 12(1) du *Hospital Insurance Regulations* qui sont reliés à cette Loi, établissent les conditions régissant la présentation par les hôpitaux et les conseils d'administration des hôpitaux au ministre de la Santé de leurs prévisions budgétaires annuelles et de leurs états mensuels de recettes et de dépenses réelles.

1.3 Vérification des comptes

Le bureau du vérificateur général de la province vérifie le programme d'assurance-médicaments. Les vérificateurs internes du ministère de la Santé examinent les états financiers du contrat d'administration de la MMC. Celle-ci fait également l'objet d'une vérification externe qui comprend l'examen du contrat d'administration. Les paiements d'assurance-santé ne font pas l'objet d'une vérification formelle. Cependant, le bureau du vérificateur général de la Nouvelle-Écosse est en voie de la recommander.

Aux termes du paragraphe 12(2) du *Hospital Insurance Regulations*, chaque conseil d'administration des hôpitaux est tenu de présenter, au plus tard le 31 mai de chaque année, un état financier vérifié de l'exercice précédent au ministre de la Santé.

Le rapport du vérificateur général de la Nouvelle-Écosse, qui a été déposé le 19 janvier 2001, renfermait trois vérifications qui sont pertinentes pour la *Loi canadienne sur la santé* :

- une vérification de large portée sur les frais modérateurs imposés par le ministère de la Santé;
- une vérification du *Cape Breton Healthcare Complex*;
- une évaluation des initiatives optionnelles de financement prévues pour la rémunération des médecins de la Nouvelle-Écosse.

1.4 Mandataire désigné

En vertu d'un protocole d'entente conclu avec le ministère de la Santé, la MMC administre les comptes des médecins et est habilité à recevoir des sommes pour payer ces comptes. La MMC reçoit une autorisation écrite du ministère de la Santé lui indiquant les bénéficiaires à qui elle peut verser des rémunérations. Les taux de rémunération et les montants précis sont fonction du contrat du médecin négocié entre la *Société médicale de la Nouvelle-Écosse* et le ministère de la Santé. La MMC se conforme aux modalités et aux conditions stipulées dans le contrat et à son mode de paiement.

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2.0 Intégralité

2.1 Services hospitaliers assurés

En Nouvelle-Écosse, 36 établissements assurent la prestation de services hospitaliers assurés aux malades hospitalisés et externes. L'agrément n'est pas obligatoire, mais la plupart des établissements sont agréés à l'échelle de l'établissement ou de la région. La loi habilitante qui prévoit la prestation de services hospitaliers assurés en Nouvelle-Écosse est la *Health Services and Insurance Act*, chapitre 197, *Revised Statutes of Nova Scotia*, 1989, articles 3(1), 5, 6, 10, 15, 16, 17(1), 18 et 35, laquelle a été adoptée par l'autorité législative en 1958. Le *Hospital Insurance Regulations* a été établi en vertu de la *Health Services and Insurance Act*.

Les services aux malades hospitalisés comprennent les services suivants :

- l'hébergement et les repas dans une chambre commune;
- les services infirmiers nécessaires;
- les services de laboratoire et de radiologie et autres procédures de diagnostic;
- les médicaments, les produits biologiques et les préparations connexes lorsqu'ils sont administrés dans un hôpital;
- les fournitures chirurgicales ordinaires;
- l'utilisation de la salle d'opération, de la salle d'attente et des installations anesthésiques;
- l'utilisation des services de radiothérapie et de physiothérapie, lorsqu'ils sont disponibles;
- la fraction ou la fraction thérapeutique de sang.

Les services aux malades externes comprennent les services suivants :

- les examens de laboratoire et de radiologie;
- les procédures de diagnostic, y compris l'utilisation de produits radiopharmaceutiques;
- les examens d'électroencéphalie;
- l'utilisation des installations d'ergothérapie et de physiothérapie, lorsqu'elles sont disponibles;
- les services infirmiers nécessaires;
- les médicaments, les produits biologiques et les préparations connexes;
- la fraction ou la fraction thérapeutique de sang;
- les services hospitaliers relatifs à la plupart des interventions médicales ou chirurgicales mineures;
- les soins de jour pour diabétiques; les services autres que les services médicaux fournis par la *Nova Scotial Hearing and Speech Clinic* ainsi que ceux fournis dans cette clinique;
- les procédures de diagnostic par ultrasons;
- la nutrition parentérale à domicile;
- l'hémodialyse et la dialyse péritonéale.

2.2 Services médicaux assurés

La loi qui prévoit la prestation de services de médecin assurés en Nouvelle-Écosse est la *Health Services and Insurance Act*, articles 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31 et 35, et le *Medical Services Insurance Regulations*.

Aux termes de la *Health Services and Insurance Act*, un omnipraticien s'entend d'une personne exerçant la médecine générale, d'un médecin n'étant pas un spécialiste au sens de l'alinéa ou d'un spécialiste qui est médecin et qui est reconnu comme spécialiste par l'organisme de réglementation professionnelle pertinent du secteur de compétence où il exerce ses fonctions. Les médecins (omnipraticiens ou spécialistes) doivent recevoir une autorisation du *College of Physicians and Surgeons* de la Nouvelle-Écosse pour facturer le régime MSI. Les dentistes qui reçoivent des rémunérations en vertu de ce régime doivent être inscrits au *Provincial Dental Board* et être reconnus comme tels. En 2000-2001, 1 946 médecins et 39 dentistes ont reçu des rémunérations grâce au régime MSI.

Les médecins se gardent le droit d'adhérer au régime MSI ou de se retirer de celui-ci. Dans le cas qui précède, il revient à un médecin

d'aviser le régime MSI et de se dessaisir de son numéro de facturation. Les malades qui paient directement le médecin qui s'est retiré du régime sont remboursés à même le régime MSI. Au 31 mars 2001, on ne comptait aucun médecin non participant.

Les services assurés sont ceux qui sont requis d'un point de vue médical pour diagnostiquer, traiter, réadapter ou modifier une structure de la morbidité. Il n'existe aucune limite pour les services assurés requis d'un point de vue médical.

En 2000-2001, aucun nouveau service assuré d'importance n'a été ajouté à la liste des services de médecin assurés. À tous les trimestres, on approuve de nouveaux codes d'honoraires spécifiques qui représentent les améliorations, les nouvelles technologies ou les nouvelles façons de fournir un service.

Une structure de comités procède à l'ajout des nouveaux codes d'honoraires à la liste des services de médecin assurés. Les médecins qui souhaitent faire reconnaître ou établir un nouveau code d'honoraires doivent au préalable soumettre leur cas à la *Société médicale de la Nouvelle-Écosse*, qui propose une valeur pour les nouveaux honoraires suggérés.

La valeur proposée est ensuite transmise au *Joint Fee and Tariff Committee*. Le comité mixte est formé d'un nombre égal de membres de la Société médicale et du ministère de la Santé. Une fois approuvés par le comité, les nouveaux honoraires suggérés sont envoyés au ministère de la Santé, aux fins d'approbation finale. La MMC est chargée d'ajouter les nouveaux honoraires au barème des services assurés remboursables par le régime MSI.

2.3 Services de chirurgie dentaire assurés

Aux termes de la *Health Services and Insurance Act*, un dentiste est une personne légalement autorisée à exercer la dentisterie dans un lieu propre à l'exercice de sa profession.

Pour fournir des services de chirurgie dentaire assurés en vertu de la *Health Services and Insurance Act*, les dentistes doivent être membres agréés de l'*Association of Dentists* et être qualifiés dans l'exercice de la chirurgie dentaire. La *Health Services and Insurance Act* stipule qu'un dentiste peut choisir de ne pas participer au régime MSI. Pour y participer, il doit s'inscrire. Un dentiste participant qui souhaite se retirer du régime est tenu d'aviser le régime MSI par écrit; il n'est ensuite plus autorisé à présenter des réclamations à ce régime. Au 31 mars 2001, aucun dentiste ne s'était retiré du régime. En 2000-2001, 39 dentistes ayant fourni des services de chirurgie dentaire assurés ont été rémunérés par l'entremise du régime MSI.

Les services de chirurgie dentaire assurés doivent être fournis dans un établissement de santé. Les services assurés sont énumérés dans le *Dental Surgical Program Fee Schedule*. Les services fournis en vertu de ce programme sont assurés lorsque les conditions du patient sont telles que l'intervention doit, sur le plan médical, être pratiquée à l'hôpital et que celle-ci se révèle de nature chirurgicale. En règle générale, les services de chirurgie dentaire assurés sont : la chirurgie orthognatique; la chirurgie destinée à l'enlèvement des dents incluses; la chirurgie buccale et maxillo-faciale. Pour ajouter des services de chirurgie dentaire assurés à la liste, il faut d'abord s'adresser à la *Dental Association of Nova Scotia*, et leur demander de présenter une proposition au ministère de la Santé. Celui-ci, après avoir consulté des experts dans ce domaine, doit faire savoir si la nouvelle intervention devient un service assuré.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Les services hospitaliers non assurés comprennent les services suivants :

- l'hébergement en chambre privée ou semi-privée à la demande du patient;
- le téléphone;
- la télévision;
- les médicaments et les produits biologiques prescrits après le congé de l'hôpital;

- la chirurgie esthétique;
- les interventions visant le rétablissement de la fécondité;
- la chirurgie transsexuelle;
- la fécondation *in vitro*;
- les interventions pratiquées dans le cadre d'essais cliniques;
- les services comme le pontage gastrique dans les cas d'obésité morbide, la chirurgie d'augmentation ou de réduction mammaire et la circoncision des nouveau-nés, sauf, exceptionnellement, si elles sont jugées nécessaires sur le plan médical;
- les services requis par un tiers (les compagnies d'assurance, par exemple) qui ne sont pas considérés médicalement nécessaires.

Les services non assurés fournis par les médecins comprennent les services suivants :

- les services auxquels le patient a droit en vertu de la *Workers' Compensation Act* ou de toute autre loi fédérale ou provinciale;
- les frais relatifs aux déplacements ou aux délais;
- les conseils ou les renouvellements d'ordonnances délivrés par téléphone;
- les examens requis par un tiers;
- les immunisations ou inoculations de groupe, à moins qu'elles ne soient autorisées par le Ministère;
- la préparation de certificats ou de rapports;
- la comparution en cour;
- les services associés à l'électrocardiographie, l'électromyographie et l'électroencéphalographie, à moins que le médecin ne soit un spécialiste dans le domaine en question;
- la chirurgie esthétique;
- l'acupuncture;
- le rétablissement de la fécondité;
- la fécondation *in vitro*.

Tous les résidents de la province ont droit aux services assurés couverts en vertu de la *Health Services and Insurance Act*. Les patients qui peuvent acheter des biens et des services améliorés (lentilles interoculaires pliables ou plâtres en fibre de verre, par exemple) doivent être informés de leurs coûts, et ne doivent pas se voir refuser les services en raison de leur incapacité de payer. La province offre des solutions de rechange à tout bien et service amélioré.

Le ministère de la Santé étudie aussi avec attention toutes les plaintes déposées par les patients ou les préoccupations du public pouvant indiquer le non-respect des principes généraux liés aux services assurés.

Pour désassurer des services médicaux, les représentants de la *Société médicale de la Nouvelle-Écosse* et du ministère de la Santé doivent entamer un processus de négociation qui leur permettra d'évaluer conjointement une intervention pour en déterminer la nécessité sur le plan médical. Si l'intervention n'est pas jugée requise sur le plan médical, elle sera retirée du barème de rémunération des médecins et ne sera plus remboursée à titre de service assuré. Lorsqu'un service n'est plus assuré, l'ensemble des interventions et des examens liés à sa fourniture deviennent également non assurés. Le même processus s'applique aux services dentaires et hospitaliers. La dernière fois qu'on a assisté au retrait d'un grand nombre de services assurés était en 1997.

3.0 Universalité

3.1 Admissibilité au régime

L'admissibilité aux services de santé assurés en Nouvelle-Écosse est indiquée à l'article 3 de la *Health Services and Insurance Act*. Tous les résidents de la Nouvelle-Écosse sont admissibles. On définit un résident comme toute personne légalement autorisée à demeurer au Canada, qui habite et vit habituellement en Nouvelle-Écosse.

Les personnes des autres provinces du Canada qui s'établissent en Nouvelle-Écosse sont habituellement admissibles au régime MSI à compter du premier jour du troisième mois qui suit le mois de leur arrivée à titre de résidents permanents. Les personnes d'autres pays qui s'établissent en permanence en Nouvelle-Écosse sont admissibles au régime à compter de la date de leur arrivée dans la province, à condition qu'elles soient citoyennes du Canada.

Les membres de la Gendarmerie royale du Canada et des Forces canadiennes, les détenus des pénitenciers fédéraux et les membres de l'Organisation du Traité de l'Atlantique Nord ne sont pas admissibles au régime MSI. Lorsque leur statut change, ils sont admissibles à compter du premier jour du troisième mois qui suit le mois de leur admissibilité.

3.2 Exigences relatives à l'inscription au régime

Pour obtenir une carte de santé, les résidents de la Nouvelle-Écosse doivent remplir un formulaire d'inscription, et y inclure le nom et l'adresse postale d'un témoin (un résident de la Nouvelle-Écosse pouvant confirmer l'exactitude des renseignements indiqués), puis le retourner au régime MSI. Les résidents doivent également joindre un certificat de naissance canadien, un certificat d'immigration canadien ou toute autre preuve stipulant qu'ils sont autorisés à demeurer au Canada. Si le formulaire de demande est rempli et que tous les critères d'admissibilité sont respectés, le régime MSI émet une carte de santé. Cette carte doit être présentée pour chaque service assuré reçu. Le régime MSI envoie des avis de renouvellement à l'adresse permanente des résidents de la Nouvelle-Écosse. Après avoir reçu un avis de renouvellement signé, le régime MSI émet une nouvelle carte de santé. Chaque demande et chaque numéro de carte de santé sont uniques et alloués sur une base individuelle.

Au 31 mars 2001, il y avait 947 963 résidents enregistrés au régime.

Il n'existe aucune loi en Nouvelle-Écosse qui oblige les résidents à s'inscrire au régime. Il y a donc des résidents qui ne sont pas inscrits au régime d'assurance-santé. Le fait de ne pas retourner un avis de renouvellement annule l'admissibilité au service jusqu'au renouvellement.

3.3 Autres catégories de personnes

Les autres catégories de personnes également admissibles à la couverture des services de soins de santé assurés en Nouvelle-Écosse, comprennent les personnes suivantes :

Immigrants – Les personnes en possession de documents d'immigrants ayant reçu le droit d'établissement et étant considérées à titre de résidents permanents sont admissibles à compter de la date de leur arrivée en Nouvelle-Écosse. Les personnes en possession de tout autre document ayant demandé le statut de résident permanent au Canada sont admissibles à compter de la date de la demande, à condition qu'elles soient en possession d'une lettre du ministère de la Citoyenneté et de l'Immigration.

Les personnes munies de visas d'emploi qui ont résidé en Nouvelle-Écosse pendant six mois ont droit à une couverture rétroactive au jour de leur arrivée, à condition qu'elles ne se soient pas absentées de la province pendant plus de 31 jours consécutifs et qu'elles aient l'intention d'y travailler pendant encore six mois.

Titulaires de permis de travail – Les personnes d'autres pays s'établissant en Nouvelle-Écosse qui sont en possession d'un permis de travail sont admissibles au régime MSI à compter du premier jour du septième mois qui suit la date de leur arrivée comme travailleur, à condition qu'elles ne se soient pas absentées de la province pendant 31 jours consécutifs (sauf en cours d'emploi).

Étudiants – Les personnes d'autres pays s'établissant en Nouvelle-Écosse qui sont en possession d'une autorisation d'étude sont admissibles au régime MSI à compter du premier jour du treizième mois qui suit le mois de leur arrivée, à condition qu'elles ne se soient

pas absentées de la province pendant plus de 31 jours consécutifs.

Personnes en congé sabbatique – Les personnes en congé sabbatique sont traitées de la même façon que les autres résidents de la province. Elles doivent revenir en Nouvelle-Écosse dans les douze mois. Les absences d'une durée supérieure aux six mois habituels doivent être approuvées au préalable avant que la couverture du régime MSI ne soit prolongée.

Réfugiés – Les réfugiés ne sont pas assurés s'ils ne sont pas légalement autorisés à demeurer au Canada. Les réfugiés comprennent les personnes en attente d'une décision de Citoyenneté et Immigration Canada concernant l'autorisation de demeurer au Canada. Les réfugiés qui possèdent un permis de travail sont assujettis aux dispositions d'admissibilité des personnes possédant un permis de travail.

Au 31 mars 2001, 928 personnes résidant en Nouvelle-Écosse étaient couvertes en vertu des modalités indiquées ci-devant.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes des autres provinces ou territoires du Canada qui s'établissent en Nouvelle-Écosse sont admissibles au régime MSI à compter de la première journée du troisième mois qui suit le mois de leur arrivée à titre de résident de la province.

4.2 Couverture durant des absences temporaires (au Canada)

Tous les cas se rapportant à la transférabilité des services assurés doivent être traités en vertu de l'Accord sur l'admissibilité et la transférabilité. En outre, plusieurs décrets, y compris le décret 72-783 (règlement du régime MSI), assurent la transférabilité.

Conformément à l'Accord sur l'admissibilité et la transférabilité, le régime MSI de la Nouvelle-Écosse offre généralement une couverture aux résidents de la province qui s'établissent ailleurs au Canada pendant une durée de trois mois. Les étudiants qui sont temporairement absents de la province et qui fréquentent un établissement d'enseignement à temps plein demeurent admissibles au régime sur une base annuelle, à condition qu'ils fournissent tous les ans une lettre faisant état de leur inscription à temps plein.

Les détenteurs d'un permis de travail qui s'absentent de la Nouvelle-Écosse à la recherche d'un emploi demeurent couverts par le régime pendant une durée pouvant aller jusqu'à douze mois, à condition qu'ils ne s'établissent pas dans une autre province, territoire ou un autre pays.

Les services fournis aux résidents de la Nouvelle-Écosse dans une autre province ou territoire sont couverts par des ententes de réciprocité. La Nouvelle-Écosse participe à l'entente de facturation réciproque des services hospitaliers et à l'entente de facturation réciproque des services médicaux. Les services hospitaliers fournis à des malades hospitalisés sont payés en vertu de l'entente de facturation réciproque interprovinciale au coût normalisé d'hospitalisation en salle commune de l'hôpital ayant fourni le service. En 2000-2001, les montants payés en vertu du régime pour des services hospitaliers fournis dans d'autres provinces et territoires totalisent 9 559 303 $ pour les malades hospitalisés, et 4 083 677 $ pour les malades externes. Dans tous les cas de facturation réciproque, la Nouvelle-Écosse paie les tarifs de la province d'accueil pour les services assurés.

4.3 Couverture durant des absences temporaires (à l'étranger)

La Nouvelle-Écosse se conforme à l'Accord sur l'admissibilité et la transférabilité dans le cas des services assurés fournis aux résidents qui sont temporairement à l'étranger. En autant qu'une personne résidente de la Nouvelle-Écosse n'est pas absente du pays pendant plus

de six mois, les services fournis à l'étranger sont payés au coût moindre en fonction du montant qu'aurait payé la Nouvelle-Écosse pour des services similaires fournis dans la province. Pour s'assurer de la couverture des interventions non urgentes par le régime MSI de la Nouvelle-Écosse, il faut obtenir une autorisation préalable.

Cependant, les étudiants qui s'absentent temporairement de la province et qui fréquentent un établissement d'enseignement à temps plein demeurent admissibles au régime MSI, à condition qu'ils fournissent une preuve de leur inscription à temps plein.

Les travailleurs qui s'absentent de la Nouvelle-Écosse à la recherche d'un emploi demeurent admissibles au régime MSI pendant une période pouvant aller jusqu'à douze mois, à condition qu'ils n'établissent pas de résidence dans un autre pays.

Les services urgents fournis à l'étranger sont payés au coût moindre en fonction du montant qu'aurait payé la Nouvelle-Écosse pour des services similaires fournis dans la province. En 2000-2001, le montant dépensé pour des services assurés urgents fournis aux malades hospitalisés et externes à l'étranger totalise 1 736 104 $ (taux quotidien = 525 $ CA).

4.4 Nécessité d'une approbation préalable

Une autorisation préalable est requise dans le cas des services facultatifs fournis dans une autre province ou à l'étranger. La demande d'autorisation préalable doit être faite auprès du directeur médical du régime MSI par un médecin de la Nouvelle-Écosse, pour le compte d'un résident assuré. Le médecin-conseil examine les modalités et les conditions, et détermine si le service est fourni dans la province, peut être fourni dans une autre province ou n'est fourni qu'à l'étranger. Le médecin-conseil fait connaître sa décision au médecin du patient. Le patient est alors couvert en vertu de l'entente de facturation réciproque pour des services facultatifs fournis dans une autre province ou un autre territoire du pays. Si un résident est autorisé à obtenir un service à l'étranger, la totalité du coût du service sera couverte dans le cadre du régime MSI.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Les services assurés sont fournis aux résidents de la Nouvelle-Écosse selon des modalités uniformes.

Aucun des régimes n'impose de frais modérateurs ou de frais supplémentaires.

Il n'y a aucun obstacle à l'accessibilité aux soins en Nouvelle-Écosse.

5.2 Accès aux services hospitaliers assurés

Le gouvernement de la Nouvelle-Écosse continue d'insister sur la prestation de services de soins de santé viables et de qualité à ses citoyens.

Au 31 mars 2001, la Nouvelle-Écosse comptait 3 044 lits d'hôpitaux pour soins actifs.

Le tableau 1 présente une ventilation des professions clés de la santé dont les membres sont autorisés à exercer en Nouvelle-Écosse. Ces professionnels de la santé n'ont pas tous participé activement à la prestation de services de santé assurés.

Tableau 1 : Personnel de santé en Nouvelle-Écosse (2000)	
Métier de santé	**Nombre d'autorisations à exercer[1]**
Médecins	1 788[2]
Dentistes	443[3]
Infirmiers (ères) autorisé(e)s	9 327
Infirmiers (ères) auxiliaires autorisé(e)s	3 349
Techniciens (nes) en radiation médicale	483
Inhalothérapeutes[4]	–
Pharmaciens	945
Ergothérapeutes	245
Orthophonistes	207
Chiropraticiens	52
Opticiens	173
Optométristes	73
Denturologistes	65
Diététiciennes	386
Psychologues	369

1 Les professionnels autorisés à exercer ne travaillent pas tous.

2 Ce ne sont pas tous les médecins qui assurent des services en vertu du système de soins de santé provincial en raison de la présence du ministère de la Défense nationale et des populations autochtones.

3 Un nombre limité de dentistes autorisés à exercer leur profession ne sont pas tous autorisés à offrir des services dentaires assurés.

4 Les données ne sont pas disponibles.

En 2000-2001, la Nouvelle-Écosse a eu recours à la télémédecine pour dispenser les services suivants (tableau 2).

Tableau 2 : Services de télémédecine en Nouvelle-Écosse (2000-2001)	
Type de services offerts par la télémédecine	**Nombre de services offerts**
Cas de téléradiologie	14 763
Séances d'étude	1 831
Consultations cliniques	729
Réunions administratives	383
Conférences sur des cas cliniques	281

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Au 31 décembre 2000, 1 757 médecins et 39 dentistes fournissaient des services assurés en vertu de la *Loi canadienne sur la santé* ou des lois provinciales. Des solutions de financement innovatrices, comme le financement global et les marchés de services personnels, ont permis d'accroître le recrutement.

La Nouvelle-Écosse a augmenté la formation médicale en médecine générale et tient aussi des activités de recrutement permanentes et a fourni le financement pour lancer un programme de réinsertion à l'intention des omnipraticiens qui souhaitent suivre une formation spécialisée après avoir effectué deux années de médecine générale dans la province.

5.4 Rémunération des médecins

La *Health Services and Insurance Act, Revised Statutes of Nova Scotia*, chapitre 197, régit la rémunération des médecins et des dentistes pour les services assurés. Les rémunérations sont versées aux médecins conformément à une entente négociée entre la *Société médicale de la Nouvelle-Écosse* et le ministère de la Santé de la Nouvelle-Écosse. La *Société médicale de la Nouvelle-Écosse* est reconnue à titre de seule agente de négociation en faveur des médecins dans la province. Au moment des négociations, des représentants de la *Société médicale de la Nouvelle-Écosse* et du ministère de la Santé discutent du financement global, des autres modalités et conditions et des améliorations que la Société médicale soumet compte tenu des restrictions financières de la province. Chaque entente négociée prévoit une clause d'arbitrage exécutoire en cas d'impasse au cours du règlement des différends. L'entente-cadre actuelle, qui est en place depuis le 1er avril 1987 et qui a pris fin le 31 mars 2001, comporte un autre mode de règlement des différends.

L'entente établit la valeur unitaire principale accordée aux services de médecin et aborde diverses questions, notamment la rémunération des médecins de garde ou de rappel, le fonds des avantages sociaux des membres, le financement de l'Association canadienne de protection médicale et le financement de la stabilisation des redevances. Elle comporte en outre une disposition concernant le remboursement de la taxe de vente harmonisée. La rémunération à l'acte demeure toujours le mode de paiement le plus courant

pour les services de médecin. Le taux de rémunération horaire, la rémunération horaire et la rémunération à la consultation figurent parmi les autres modes.

En 2000-2001, les paiements aux médecins de la Nouvelle-Écosse ont été de 220 399 923 $. Le Ministère a payé 4 766 189 $ de plus pour des services médicaux rendus dans d'autres provinces et territoires du Canada.

Les taux de rémunération des services dentaires de la province sont négociés entre le ministère de la Santé et la *Nova Scotia Dental Association*. Le processus de négociation de ces taux est semblable à celui des services de médecin. Les dentistes sont rémunérés à l'acte. L'actuelle entente a pris fin le 31 mars 2001.

5.5 Paiements aux hôpitaux

Le ministère de la Santé de la Nouvelle-Écosse fixe les objectifs budgétaires. Pour ce faire, il reçoit les plans d'activités des neuf autorités sanitaires de district nouvellement créées et du Centre de santé IWK. Les prévisions approuvées constituent la base sur laquelle sont fondés les paiements versés à ces organisations à des fins de prestation des services.

La *Health Authorities Act* a reçu l'assentiment royal le 8 juin 2000. Cette nouvelle loi créait les neuf autorités sanitaires de district qui remplacent les anciennes autorités sanitaires régionales de la province. Ce changement est entré en vigueur en janvier 2001 en vertu du *District Health Authorities General Regulations*. La mise en place de conseils de santé communautaires en vertu du *Community Health Boards' Member Selection Regulations* est entrée en vigueur en avril 2001. Les autorités sanitaires de district sont chargées (en vertu de l'article 20 de la Loi) de surveiller la prestation des services de santé dans leurs districts et sont pleinement responsables d'expliquer les décisions dans les plans de santé communautaire par le truchement de leurs plans d'activités qu'ils soumettent au ministère de la Santé.

L'article 10 de la *Health Services and Insurance Act* et les articles 9 à 13 du *Hospital Insurance Regulations*, définissent les modalités de paiement par le ministre de la Santé des services hospitaliers assurés aux hôpitaux.

En 2000-2001, il y avait un nombre total de 3 044 lits d'hôpital (3,1 par 1 000 résidents) en Nouvelle-Écosse. Les dépenses directes du ministère de la Santé pour les coûts de fonctionnement des services hospitaliers assurés sont passées à 877,02 millions de dollars. Les paiements aux hôpitaux à l'extérieur de la province pour les services assurés rendus à des résidents de la Nouvelle-Écosse ont été de 9,6 millions de dollars. Le nombre total de radiations d'hôpitaux ont été de 201 415.

6.0 Reconnaissance accordée aux transferts fédéraux

La *Health Services and Insurance Act, Revised Statutes of Nova Scotia*, chapitre 197, reconnaît la contribution versée par le gouvernement fédéral à la Nouvelle-Écosse relativement au coût des services hospitaliers assurés et des services de santé assurés fournis aux résidents de la province. Les résidents de la Nouvelle-Écosse sont au courant des négociations continues qui se déroulent entre les provinces et le gouvernement fédéral grâce aux communiqués de presse et à la couverture médiatique, et savent que le financement fédéral versé au titre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS) contribue partiellement à la prestation des services médicaux assurés dans la province.

Le gouvernement de la Nouvelle-Écosse a également reconnu la contribution fédérale au titre du TCSPS dans divers documents publiés, y compris les documents suivants diffusés en 2000-2001 :

- *Public Accounts 1999-2000*;
- *Budget Estimates 2001-2002*;
- *Department of Finance Year End Forecast*.

7.0 Services complémentaires de santé

Les services indiqués ci-après ne sont pas considérés comme étant requis sur le plan médical et, à ce titre, ne constituent pas des services assurés en vertu de la *Loi canadienne sur la santé*.

Centres de soins infirmiers

En Nouvelle-Écosse, les centres de soins infirmiers fournissent principalement des soins de niveaux I et II aux aînés. Les soins de niveau I visent les résidents des centres de soins infirmiers qui requièrent des soins personnels et de l'aide pour effectuer leurs activités quotidiennes. Les soins de niveau II incluent ceux du niveau I, plus des soins infirmiers spécifiques. Les soins de niveau II augmentent de façon importante au fur et à mesure que la population vieillit. Le phénomène du vieillissement sur place s'entend des aînés de niveau I qui passent rapidement au niveau II.

Soins en établissement pour adultes

En Nouvelle-Écosse, les soins en établissement pour adultes continuent de relever du ministère des Services communautaires et ne sont pas considérés comme des services assurés aux fins de la *Loi canadienne sur la santé*.

Services de soins à domicile

Le programme *Home Care Nova Scotia* a été introduit en 1995. Ce programme permet aux aînés de rester plus longtemps dans leur domicile, ce qui retarde leur admission dans un établissement de soins de longue durée. Le programme *Home Care Nova Scotia* fournit principalement des soins personnels au domicile des clients et des soins infirmiers, s'il y a lieu. Il comporte deux volets importants : les soins de longue durée et les soins actifs. Le premier volet compte pour environ 80 pour cent des clients, et le deuxième compte pour 15 à 20 pour cent des clients, ce qui permet d'obtenir des congés hâtifs de l'hôpital. Le programme englobe aussi un programme d'oxygénothérapie à domicile, lequel est encore en voie d'élaboration. D'autres éléments s' y ajouteront dans l'avenir : ergothérapie/ physiothérapie; travail social; soins palliatifs; pédiatrie; autres services jugés nécessaires.

La Nouvelle-Écosse a entrepris un projet pilote sur un modèle d'accès à inscription unique, et prévoit la mise en œuvre intégrale du modèle d'ici au 1er avril 2002.

Nouveau-Brunswick

Introduction

Au Nouveau-Brunswick, il existe actuellement huit corporations hospitalières régionales qui dispensent des services de santé. Chacune d'elles comprend un établissement régional et un certain nombre d'établissements plus petits qui offrent tous des services assurés aux malades hospitalisés et aux malades externes. Chaque corporation hospitalière régionale regroupe d'autres établissements ou centres de santé sans lits désignés qui offrent un éventail de services aux personnes admissibles.

Le Nouveau-Brunswick compte environ 750 000 habitants, dont 33 p. 100 sont francophones. Les corporations hospitalières régionales ont le mandat de dispenser des services à tous les segments de la population.

Il existe trois catégories générales de programmes hospitaliers. Elles ont été établies en fonction de la complexité des procédures et des traitements ainsi que de l'intensité en ressources. Ces programmes sont répartis de façon à ce que le système soit aussi équitable et praticable que possible sur les plans clinique et financier. Des soins primaires sont dispensés dans tous les établissements hospitaliers. Quant aux soins secondaires, qui sont des soins spécialisés reposant sur des procédures de diagnostic et des traitements plus sophistiqués et plus compliqués, ils sont en grande partie dispensés dans les établissements de plus grande taille. Dans certains cas où les services sont encore plus spécialisés, tels la médecine nucléaire, les soins secondaires sont offerts dans les huit hôpitaux régionaux. Quant aux soins tertiaires, ils sont offerts uniquement dans quelques centres désignés et, dans certains cas, ces services peuvent être désignés comme étant des services provinciaux. À titre d'exemple, l'unité de chirurgie cardiaque située dans la région 2 (Saint John) a un mandat provincial.

Le Conseil de la qualité de la santé du premier ministre a été mis sur pied en janvier 2000. Il a pour mandat de formuler des recommandations au gouvernement sur le renouvellement du système de santé du Nouveau-Brunswick. Au printemps 2001, un document de travail a été publié. Il avait pour objet d'ouvrir une discussion avec les Néo-Brunswickois concernant les meilleurs moyens de mettre sur pied un système de santé communautaire durable axé sur la personne.

La réflexion amorcée dans ce document de travail n'est que préliminaire et le Conseil a demandé l'opinion des Néo-Brunswickois quant aux idées formulées initialement. Le compte rendu de leurs commentaires occupera une grande partie du rapport final que doit être publié à la fin de 2002.

L'une des recommandations veut que la province mette sur pied huit commissions de régies régionales de la santé appelées à jouer le rôle d'organisme de réglementation pour huit régies régionales de la santé. Hormis quelques modifications mineures, les RRS refléteront les limites actuelles déterminées pour la santé.

À l'instar d'autres provinces et territoires, le Nouveau-Brunswick essaie d'assurer la durabilité de son système de santé. Les dépenses totales du ministère de la Santé et du Mieux-être représentent environ 28 p. 100 des dépenses totales du gouvernement. Le budget du Ministère a été augmenté dans une proportion supérieure à celui du budget provincial global. Les dépenses réelles du Ministère ont augmenté de 5,8 p. 100 en 2000-2001, alors que les dépenses de la province ont augmenté de 3,6 p. 100.

Le 1er avril 2001, le ministère de la Santé et du Mieux-être a lancé une « Stratégie des ressources en soins infirmiers pour le Nouveau-Brunswick » qui s'échelonnera sur une période de trois ans. Cette stratégie accroîtra la capacité des corporations hospitalières régionales de recruter du personnel infirmier et de le maintenir en poste.

On trouve d'autres renseignements sur le site web du gouvernement à l'adresse www.gnb.ca, qui comporte un lien avec le ministère de la Santé et du Mieux-être.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Au Nouveau-Brunswick, l'assurance-santé est connue sous le nom de régime de services médicaux. En vertu de la *Loi sur le paiement des services médicaux*, promulguée le 1er janvier 1971, et de son règlement d'application, le ministre de la Santé du Mieux-être est l'instance publique responsable de la gestion et du fonctionnement du régime.

La Loi et son règlement stipulent les critères d'admissibilité, les droits des prestataires et les responsabilités de l'autorité provinciale, lesquelles comprennent l'établissement d'un régime de services de santé et la définition des services assurés et non assurés. La Loi régit également les types d'accords que l'autorité provinciale peut conclure avec d'autres provinces ou territoires et avec la Société médicale du Nouveau-Brunswick, de même que les droits des médecins, le mode de détermination des montants à payer pour des services autorisés, le mode d'évaluation des comptes pour des services autorisés ainsi que les questions relatives à la confidentialité et à la protection des renseignements personnels, dans la mesure où celles-ci sont liées à l'exécution de la Loi.

Le ministre de la Santé et du Mieux-être est responsable de l'établissement d'un régime de services médicaux, en vertu duquel on détermine qui sont les prestataires du régime, quels services sont et ne sont pas couverts ainsi que les montants à payer pour les services autorisés. Dans le cadre de ce régime, le ministre évalue et vérifie les factures présentées par les médecins par l'entremise d'inspecteurs qu'il a lui-même nommés et d'un comité de revue professionnelle, comme il est prévu aux articles 24(1) à 33 du Règlement pris en application de la *Loi sur le paiement des services médicaux*. Le ministre a également le pouvoir de recouvrer les coûts de services autorisés auprès d'une personne négligente.

1.2 Liens hiérarchiques

La direction de l'Assurance-maladie de la division de la Santé publique et des Services médicaux du ministère de la Santé et du Mieux-être est chargée de la gestion du régime. Le Ministre s'acquitte de son obligation de rendre compte, soit au moyen du rapport annuel du Ministère, soit dans le cadre du processus législatif habituel.

En février 2000, le gouvernement du Nouveau-Brunswick a adopté un cadre pour la responsabilisation des corporations hospitalières régionales conformément aux indications données dans le document Miser sur nos forces – Cadre d'action sur l'imputabilité des corporations hospitalières régionales. Ce document décrit les rôles respectifs du Ministère et des corporations hospitalières régionales et établit le Comité de planification du système de corporations hospitalières régionales ainsi que le principal processus à la base de la responsabilisation des corporations hospitalières régionales.

1.3 Vérification des comptes

Trois groupes distincts ont pour mandat de procéder à des vérifications concernant le régime de services médicaux.

1. Vérificateur général

- En vertu de la *Loi sur le vérificateur général*, le Bureau du vérificateur général procède à la vérification externe des comptes de la province du Nouveau-Brunswick, laquelle englobe les dossiers financiers du ministère de la Santé et du Mieux-être. Pour l'exercice 2000-2001, toutes les transactions du Ministère ont été assujetties à la vérification. Ces procédures sont suivies de façon systématique chaque année. À la suite de la vérification, le vérificateur général publie une lettre de recommandations ou un rapport sur les erreurs relevées et les faiblesses du contrôle.

2. Bureau du contrôleur

- Le contrôleur est le vérificateur interne en chef de la province du Nouveau-Brunswick. Il est chargé de mener à bien les activités de

vérification interne conformément aux responsabilités et pouvoirs que lui confère la *Loi sur la gestion des finances publiques*. Dans le cadre d'une vérification interne, le contrôleur a pour mandat couvrir tous les aspects suivants : vérification des affectations de crédit, des systèmes d'information, de l'optimisation des ressources et vérifications légales. Le travail de vérification accompli par le Bureau varie selon la nature de l'entité vérifiée;

- Aucun examen n'a été fait pour l'exercice 2000-2001.

3. Vérification interne du ministère de la Santé et du Mieux-être

- Le groupe de vérification interne du Ministère a pour mandat d'examiner et d'évaluer de façon indépendante les activités du Ministère, à tous les niveaux de la gestion. Ce groupe est chargé de fournir à la direction de l'information sur l'adéquation et l'efficacité du système de contrôle interne et sur sa conformité à la Loi et aux politiques établies. Il procède à des vérifications des programmes et produit des rapports sur l'efficacité de ces derniers en regard de l'atteinte des objectifs du Ministère;
- Les examens des secteurs des programmes sont habituellement effectués de façon cyclique, chaque programme important faisant l'objet d'un examen une fois tous les trois à quatre ans. Aucun examen de ces programmes n'a été effectué au cours de l'exercice 2000-2001.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les services hospitaliers assurés sont assujettis à la :

- *Loi sur les services hospitaliers (1973)* et à son Règlement 86-74. L'article 9 du *Règlement* détermine les services autorisés.
- *Loi hospitalière*, sanctionnée le 20 mai 1992 et son Règlement 92-84.

La Loi établit huit corporations hospitalières régionales. Chacune d'elles comprend un établissement régional et un certain nombre d'établissements plus petits qui offrent tous des services assurés aux malades hospitalisés et aux malades externes. Chaque corporation hospitalière régionale regroupe d'autres établissements ou centres de santé sans lits désignés qui offrent un éventail de services autorisés aux personnes admissibles. À l'Annexe 1 de la présente section, on trouve la liste des établissements des corporations hospitalières régionales classée selon leur type. Il est à remarquer que les établissements sont classés selon qu'ils comportent des lits pour soins actifs et qu'ils n'offrent pas de services aux patients hospitalisés.

En vertu du Règlement 84-167 de la *Loi sur les services hospitaliers*, les résidents du Nouveau-Brunswick sont admissibles aux services hospitaliers assurés suivants :

(a) services internes dans un établissement hospitalier exploité par une corporation hospitalière agréée, et notamment

(i) le logement et les repas conformes à ceux d'une salle ordinaire;

(ii) les soins infirmiers nécessaires;

(iii) les actes de diagnostic et notamment les services de laboratoire et de radiologie de même que les interprétations nécessaires, en vue de préserver la santé, prévenir la maladie et faciliter le diagnostic et le traitement de toute blessure, maladie ou incapacité;

(iv) les produits pharmaceutiques, les substances biologiques et les préparations connexes ainsi qu'il est prévu à l'annexe 2;

(v) l'utilisation de la salle d'opération, de la salle d'accouchement et des installations anesthésiques, y compris le matériel et les fournitures nécessaires;

(vi) les fournitures chirurgicales courantes;

(vii) l'utilisation des installations de radiothérapie, s'il y en a;

(viii) l'utilisation des installations de physiothérapie, s'il y en a; et

(ix) les services rendus par des personnes qui sont rémunérées par la corporation hospitalière à cet égard; et

(b) Les services externes dans un établissement hospitalier exploité par une corporation hospitalière agréée, et notamment :

(i) les actes de diagnostic et notamment les services de laboratoire de même que les interprétations nécessaires lorsque les personnes assurées sont référées par un médecin et que les installations agréées sont disponibles;

(i.1) les actes de diagnostic et notamment les services de laboratoire de même que les interprétations nécessaires, lorsque les installations agréées sont disponibles, s'ils sont effectués aux fins d'un service de dépistage mammographique approuvé par le Ministre, et

(ii) les services externes offerts par l'hôpital lorsqu'ils sont prescrits par un médecin et rendus dans la clinique externe d'une corporation hospitalière agréée en vue de préserver la santé, de prévenir la maladie et de faciliter le diagnostic et le traitement de toute blessure, maladie ou incapacité, à l'exception des services suivants :

(A) les médicaments brevetés;

(B) les médicaments que le malade apporte à la maison;

(C) les services de diagnostic rendus au profit de tierces parties tels qu'employeurs et compagnies d'assurance;

(D) visites ayant pour seul objet l'administration de médicaments, de sérum ou de substances biologiques; et

(E) tout service externe assuré au titre de la *Loi sur le paiement des services médicaux*.

2.2 Services médicaux assurés

La loi habilitante qui prévoit la prestation de services médicaux assurés au Nouveau-Brunswick est la *Loi sur le paiement des services médicaux (LPSM)*.

La LPSM a été sanctionnée le 6 décembre 1968. Le Règlement 84-29 a été déposé le 13 février 1984, le Règlement 93-143, le 26 juillet 1993, le Règlement 96-113, le 29 novembre 1996 et le Règlement 84-20 de l'annexe 4 (se rapportant aux services de chirurgie dentaire), le 13 avril 1999.

Aucun changement n'est entré en vigueur en 2000-2001.

Le régime de services médicaux du Nouveau-Brunswick couvre les médecins qui fournissent des services médicalement nécessaires. Les conditions qu'un médecin doit remplir pour participer au régime de services médicaux du Nouveau-Brunswick sont les suivantes :

- être inscrit et autorisé par le Collège des médecins et chirurgiens du Nouveau-Brunswick;
- être membre de la Société médicale du Nouveau-Brunswick;
- détenir des privilèges dans une corporation hospitalière régionale;
- être signataire de l'entente des médecins participants.

Au 31 mars 2001, il y avait 1 355 médecins qui adhéraient à la *Loi sur le paiement des services médicaux*.

Les médecins du Nouveau-Brunswick ont la possibilité de se retirer du régime pour l'ensemble des services ou pour certains d'entre eux. Les médecins qui ont opté pour le retrait ne sont pas directement payés par l'assurance-maladie pour les services qu'ils dispensent. Ils doivent directement facturer leurs patients dans tous les cas. Les patients ne sont pas admissibles à un remboursement de l'assurance-maladie.

Les médecins ne peuvent pas se prévaloir de la disposition relative au retrait dans le cas d'une urgence ou pour la continuation de soins entrepris sous couvert du régime. Si un médecin participant désire se retirer du régime pour un service particulier, il doit, au préalable, obtenir le consentement du patient à être traité sans couverture, après quoi il peut facturer directement le patient pour le service dispensé. Dans ces cas, le médecin doit toujours suivre la procédure suivante. Il doit aviser le patient à l'avance et respecter les dispositions suivantes :

a) Si les frais n'excèdent pas le tarif de l'assurance-maladie, le médecin doit remplir

les formulaires de réclamation de l'assurance-maladie prescrits et indiquer le montant total exact exigé du patient. Le prestataire demande un remboursement en certifiant, sur le formulaire de réclamation, qu'il a bien reçu les services et en envoyant le formulaire au bureau d'assurance-maladie;

b) Si les frais excèdent le tarif de l'Assurance-maladie, le médecin doit fournir les renseignements suivants au patient avant de dispenser le service :

- ils se retirent du régime et les frais excèdent le tarif;
- en acceptant de recevoir le service dans ces conditions, le prestataire renonce à tous ses droits d'obtenir un remboursement de l'assurance-maladie;
- le patient a le droit de se procurer ces services auprès d'un autre médecin qui participe au régime.

Le médecin doit obtenir une renonciation signée du patient sur le formulaire spécifié et envoyer celui-ci au bureau de l'assurance-maladie.

Au 31 mars 2001, aucun médecin dispensant des services de santé n'avait choisi de se retirer du régime.

L'éventail des services autorisés par l'assurance-maladie du Nouveau-Brunswick comprend l'aspect médical de tous les services médicalement requis dispensés par les médecins. Il comprend également certaines procédures de chirurgie dentaire lorsqu'elles sont pratiquées, soit par un médecin, soit par un chirurgien dentiste dans un hôpital.

Toute personne, tout médecin ou le Ministère de la Santé et du Mieux-être peut demander l'ajout d'un nouveau service. Toutes les demandes sont étudiées par le comité chargé de l'ajout des nouveaux services, lequel est géré conjointement par la Société médicale du Nouveau-Brunswick et le Ministère. La décision d'ajouter un service se fonde habituellement sur la notion de « nécessité médicale » et sur le fait que le service est considéré comme une pratique généralement acceptable (non expérimentale) au Nouveau-Brunswick et au Canada. La notion de « nécessité médicale » s'applique aux services médicalement nécessaires pour maintenir la santé, prévenir les maladies et pour diagnostiquer ou traiter une blessure, une maladie ou une déficience. Aucun processus de consultation publique n'est utilisé.

2.3 Services de chirurgie dentaire assurés

Seuls les spécialistes en chirurgie buccale et maxillo-faciale peuvent fournir l'éventail des services de chirurgie dentaires couverts par l'assurance-maladie du Nouveau-Brunswick. Un dentiste peut être rémunéré pour assister un autre dentiste dans la prestation de services qui doivent, pour des raisons médicales, être dispensés dans un hôpital et qui sont compris dans l'annexe 4 du Règlement 84-20 (déposé le 23 juin 1998) de la *Loi sur le paiement des services médicaux*. L'annexe 4 précise les services de chirurgie dentaire qui peuvent être fournis par un médecin qualifié dans un hôpital si l'état du patient exige que ces services soient dispensés dans un hôpital.

Pour participer au régime de services médicaux, les dentistes doivent être inscrits à la Société dentaire du Nouveau-Brunswick et remplir l'entente des médecins participants (incluse dans le formulaire d'inscription à l'assurance-maladie du Nouveau-Brunswick/services dentaires).

Il y a 57 dentistes inscrits à l'assurance-maladie du Nouveau-Brunswick, mais plusieurs d'entre eux ne dispensent pas de services assurés.

Les dentistes peuvent se prévaloir de la même disposition de retrait du régime que les médecins et ils doivent suivre les même lignes directrices. Le Ministère ne possède pas de données sur le nombre de dentistes non participants au Nouveau-Brunswick.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Services hospitaliers non assurés

Les services non assurés comprennent :

- les médicaments brevetés;
- les médicaments que le malade emporte à la maison;
- les services diagnostiques rendus au profit d'un tiers;
- les visites pour l'administration de médicaments, de vaccins, de sérums ou de produits biologiques;
- la télévision ou le téléphone;
- l'hébergement en chambre privée ou semi-privée à la demande du patient;
- les services hospitaliers directement associés aux services énumérés dans l'annexe 2 du Règlement de la *Loi sur le paiement des services médicaux*.

Les services offerts aux personnes admissibles à d'autres régimes d'assurance fédéraux, provinciaux ou territoriaux ne sont pas couverts.

Il n'existe pas de politiques ni de lignes directrices spécifiques, autres que la Loi et ses Règlements, pour garantir que les frais perçus pour des produits ou services médicaux non assurés (c.-à-d. produits ou services améliorés tels que des lentilles intraoculaires, des pièces coulées en fibre de verre, etc.) fournis en combinaison avec un service de santé assuré ne compromettent pas l'accès raisonnable aux services assurés.

Services médicaux et de chirurgie dentaire non assurés

Les services énumérés à l'annexe 2 du Règlement 84-20 de la *Loi sur le paiement des services médicaux* sont spécifiquement exclus de la gamme des services autorisés par l'Assurance-maladie. Il s'agit nommément :

a) la chirurgie plastique facultative ou autres services à fins esthétiques;

a.01) la correction d'un mamelon inverti;

a.02) l'élargissement des seins;

a.03) l'otoplastie pour les personnes de plus de dix-huit ans;

a.04) l'ablation de petites lésions de la peau, sauf si elles risquent de se cancériser;

a.1) l'avortement, sauf lorsqu'effectué par un spécialiste en obstétrique et en gynécologie à un établissement hospitalier approuvé par la juridiction où est situé l'établissement hospitalier, et que deux médecins ont certifié par écrit que l'avortement était médicalement nécessaire;

a.2) l'assistance chirurgicale pour les opérations de la cataracte, sauf si l'assistance est requise en raison des risques d'échec opératoire, à l'exception des risques inhérents à l'enlèvement-même de la cataracte, en raison de l'existence d'une maladie ou autre complication;

b) les remèdes, les médicaments, le matériel, les fournitures de chirurgie ou les dispositifs prothétiques;

c) les vaccins, sérums, médicaments et préparations biologiques énumérés aux articles 106 et 108 du Règlement du Nouveau-Brunswick 88-200 établi en vertu de la Loi sur la santé;

d) les consultations ou les renouvellements d'ordonnance par téléphone qui ne sont pas spécifiquement prévus dans le Cahier des tarifs;

e) l'examen de dossiers ou certificats médicaux à la demande d'une tierce personne ou autres services prescrits par les règlements administratifs régissant l'hôpital ou le personnel médical;

f) les services dentaires dispensés par un médecin;

f.1) les services qui sont généralement considérés au Nouveau-Brunswick comme étant expérimentaux ou qui sont fournis à titre de recherche appliquée;

f.2) les services qui sont fournis conjointement avec ceux qui sont visés à l'alinéa f.1) ou relativement à ceux-ci;

h) le témoignage devant une cour ou tout autre tribunal;

i) les immunisations, examens ou certificats pour fins de voyage, d'emploi, d'émigration, d'assurance ou faits à la demande d'une tierce personne;

j) les services dispensés par des médecins aux membres de leur famille immédiate;

k) la psychanalyse;

l) l'électrocardiographie (E.C.G.) lorsqu'elle n'est pas effectuée par un spécialiste en médecine interne ou en pédiatrie;

m) les actes de laboratoire non compris dans le tarif d'un examen ou d'une consultation;

n) la détermination de vices de réfractions;

n.1) des services dispensés dans la province par des médecins ou des dentistes et dont les droits excèdent le montant payable en vertu du présent règlement;

o) l'ajustage et la fourniture de lunettes ou lentilles de contact;

p) la chirurgie transsexuelle;

p.1) les services de radiologie dispensés dans la province par une clinique privée de radiologie.

q) l'acuponcture;

r) un examen médical complet effectué dans le cadre d'un examen périodique et non pour des raisons de nécessité médicale;

s) la circoncision des nouveaux-nés;

t) l'inversion de vasectomies;

u) une deuxième injection ou toute injection subséquente pour impuissance;

v) l'inversion d'une ligature des trompes;

w) l'insémination intra-utérine;

x) la gastroplastie ou le contournement de l'estomac; et

y) la ponction veineuse lorsqu'elle est effectuée aux fins d'un prélèvement sanguin et en tant que procédure unique dans un endroit autre qu'un établissement hospitalier agréé.

Tous les services dentaires qui ne sont pas spécifiquement énumérés dans l'annexe 4 sur les soins dentaires ne sont pas couverts par le régime. Les services médicaux énumérés à l'annexe 2 sont considérés comme les seuls services médicaux non assurés.

La décision de retirer un service médical ou de chirurgie dentaire de la liste des services assurés est fondée sur la correspondance du service à la définition de « nécessité médicale », sur l'examen des régimes de services de santé en place au pays et sur l'utilisation antérieure de ce service particulier. Une fois que le retrait du service a été décidé, la *Loi sur le paiement des services médicaux* stipule que le gouvernement ne peut apporter aucune modification au Règlement avant d'avoir reçu l'avis et les recommandations de la Société médicale du Nouveau-Brunswick ou avant que le délai imparti à cette dernière, par le ministre, pour fournir son avis et ses recommandations, ne soit expiré. À la suite de la réception de l'avis et de la résolution de toutes les questions soulevées, une modification réglementaire est remplie. Les médecins en sont informés par écrit à la suite de l'émission de l'avis d'approbation. Le public est habituellement informé par les médias. Aucune consultation publique n'est menée.

Aucun service médical ou de chirurgie dentaire n'a été retiré de la liste des services assurés au cours de l'exercice 2000-2001.

3.0 Universalité

3.1 Admissibilité au régime

La *Loi sur le paiement des services médicaux* et son Règlement 84-20, articles 3 et 4, définissent l'admissibilité à l'assurance-maladie.

Les résidents doivent remplir une demande d'inscription à l'assurance-maladie et fournir la preuve de leur citoyenneté canadienne, de leur statut d'Autochtone ou, encore, un permis d'immigration canadien valide. Un résident est défini comme une personne légalement autorisée à être ou à demeurer au Canada, qui élit domicile et qui est habituellement présente au Nouveau-Brunswick; elle exclut les touristes, les personnes de passage et les visiteurs de la province.

Toute personne qui entre ou qui revient au Nouveau-Brunswick se voit imposer une période d'attente avant de devenir admissible au régime. La protection débute le premier jour du troisième mois suivant le mois d'arrivée. Une exception a été faite pour accorder une couverture, dès le premier jour, aux missionnaires de bonne foi qui étaient inscrits

comme résidents du Nouveau-Brunswick au moment de leur départ du pays.

Les résidents qui ne sont pas admissibles sont les suivants :

- les membres réguliers des Forces canadiennes;
- les membres de la Gendarmerie royale du Canada;
- les détenus sous responsabilité fédérale;
- les personnes en provenance d'une autre province qui sont entrées au Nouveau-Brunswick dans le but de poursuivre leur formation et qui sont admissibles à la couverture du régime de services médicaux de cette province; et
- Les non-Canadiens qui sont titulaires de certains types de permis d'immigration canadiens (par exemple, un permis de séjour pour étudiants).

Disposition prévue pour l'admissibilité :

- les non-Canadiens qui détiennent un permis d'immigration qui, normalement, ne les autoriserait pas à bénéficier de la couverture, sont admissibles s'ils sont légalement mariés à un résident du Nouveau-Brunswick admissible.

Dispositions prévues lors du changement de statut :

- Les membres des Forces canadiennes, de la Gendarmerie royale du Canada ou les détenus sous responsabilité fédérale sont admissibles au régime à compter de la date de leur libération ou de leur élargissement s'ils résidaient au Nouveau-Brunswick à cette date. Ils doivent remplir une demande et indiquer la date officielle de la libération ou de l'élargissement ainsi qu'une preuve de citoyenneté.

3.2 Exigences relatives à l'inscription au régime

Un prestataire qui souhaite devenir admissible au régime doit s'inscrire, pour lui-même et pour toutes les personnes à sa charge âgées de moins de 19 ans, en remplissant un formulaire d'inscription fourni par le bureau de l'assurance-maladie à cette fin, ou, encore, il doit être inscrit par une personne agissant en son nom.

Une fois la demande approuvée, le prestataire et les personnes à sa charge sont inscrits, et une carte d'assurance-maladie munie d'une date d'expiration est émise pour chacun d'entre eux.

Un avis d'expiration comportant toute l'information familiale enregistrée à cette date dans les dossiers d'assurance-maladie est envoyé au prestataire deux ou trois mois avant la date d'expiration de la carte d'assurance-maladie. Un prestataire qui souhaite demeurer admissible au régime doit confirmer l'information qui figure sur l'avis d'expiration, apporter tous les changements pertinents, signer le formulaire et le renvoyer au bureau de l'assurance-maladie. Le dossier est mis à jour sur réception du formulaire rempli, et une nouvelle carte est émise, accompagnée d'une nouvelle date d'expiration.

À l'heure actuelle, au Nouveau-Brunswick, seules les personnes considérées comme admissibles sont effectivement inscrites.

Tous les membres de la famille, c'est-à-dire, le prestataire, son conjoint et les personnes à charge de moins de 19 ans doivent s'inscrire comme une unité familiale. Les résidents qui cohabitent sans être légalement mariés peuvent s'inscrire comme une unité familiale s'ils en font la demande.

Au 31 mars 2001, il y avait 738 598 résidents inscrits.

Les résidents peuvent choisir de se retirer du régime. On leur demande alors de signifier leur intention par écrit. Ces renseignements sont ensuite ajoutés à leur dossier, et les prestations prennent fin. Au 31 mars 2001, seulement trois résidents avaient décidé de se retirer du régime.

3.3 Autres catégories de personnes

Les non-Canadiens qui sont titulaires d'un permis d'immigration qui, normalement, ne les autoriserait pas à bénéficier de la couverture de l'assurance-maladie sont admissibles s'ils sont légalement mariés à un résident admissible du Nouveau-Brunswick et s'ils demeurent en possession d'un permis d'immigration valide. Au moment du renouvellement, ils doivent fournir leur document d'immigration mis à jour. Environ 50 personnes étaient assurées dans ces conditions au cours de l'exercice 2000-2001.

4.0 Transférabilité

4.1 Délai minimal de résidence

Il y a une période d'attente de trois mois. La couverture prend effet le premier jour du troisième mois suivant le mois d'arrivée.

4.2 Couverture durant des absences temporaires (au Canada)

La *Loi sur le paiement des services médicaux*, Règlement 84-20, articles 3 (4) et 3 (5) définit la transférabilité de l'assurance-santé au Canada lors d'un séjour temporaire au Canada.

Les étudiants qui fréquentent à temps plein une université ou un autre établissement d'enseignement approuvé et qui quittent le Nouveau-Brunswick pour poursuivre leur formation dans une autre province bénéficient d'une couverture pour une période de douze mois renouvelable, aux conditions suivantes :

- ils communiquent avec le bureau d'assurance-maladie tous les douze mois pour conserver leur admissibilité;
- ils n'établissent pas de résidence à l'extérieur du Nouveau-Brunswick;
- ils ne bénéficient pas d'une assurance-maladie dans une autre province.

Les résidents qui sont temporairement employés dans une autre province ou territoire bénéficient d'une couverture pouvant aller jusqu'à douze mois, selon les conditions suivantes :

- ils n'établissent pas de résidence à l'extérieur de la province;
- ils ne bénéficient pas d'une couverture dans une autre province ou territoire
- ils ont l'intention de revenir au Nouveau-Brunswick.

Lorsque les résidents s'absentent pour plus de douze mois, ils doivent demander une couverture dans la province ou le territoire où ils sont employés et ils devraient y être admissibles le premier jour du treizième mois.

Le Nouveau-Brunswick a conclu des accords officiels avec toutes les provinces et les territoires pour la facturation réciproque des services hospitaliers assurés. Le Nouveau-Brunswick a également conclu des accords réciproques avec toutes les provinces pour la prestation des services médicaux assurés, à l'exception du Québec. Les services fournis par des médecins du Québec à des patients du Nouveau-Brunswick sont payés selon le tarif en vigueur au Québec si les services sont assurés au Nouveau-Brunswick. La majorité des réclamations de cette nature proviennent directement des médecins du Québec. Toute réclamation payée soumise par le patient est remboursée conformément aux règlements du Nouveau-Brunswick.

Sommes versées par le Nouveau-Brunswick aux autres provinces et territoires durant l'exercice 2000-2001 :

Services à des malades hospitalisés	Services à des malades externes	Services médicaux
21 561 907 $	4 702 219 $	7 697 923 $

4.3 Couverture durant des absences temporaires (à l'étranger)

La *Loi sur le paiement des services médicaux*, Règlement 84-20, articles 3 (4) et 3 (5) définit la transférabilité de l'assurance-maladie durant des séjours temporaires à l'étranger

Les étudiants qui fréquentent à temps plein une université ou un autre établissement d'enseignement approuvé et qui quittent le Nouveau-Brunswick pour poursuivre leur formation dans un autre pays bénéficient de la couverture pour une période de douze mois renouvelable, aux conditions suivantes :

- ils fournissent une preuve d'inscription;
- ils communiquent avec le bureau de l'assurance-maladie tous les douze mois pour conserver leur admissibilité;
- ils n'établissent pas leur résidence permanente à l'extérieur du Nouveau-Brunswick;
- ils ne bénéficient pas d'une assurance-maladie ailleurs.

Employés temporaires : Les résidents qui sont employés temporairement à l'extérieur du pays bénéficient d'une couverture pouvant aller jusqu'à douze mois, même si l'on sait à l'avance qu'ils seront absents pour une période plus longue, pourvu qu'ils n'établissent pas de résidence à l'extérieur du pays. Toute absence de plus de 182 jours, que ce soit pour raisons de travail ou de vacances, nécessite une « approbation du directeur ». Cette approbation ne peut être accordée que pour une période n'excédant pas douze mois et une seule fois tous les trois ans. Les familles de ces résidents sont toujours couvertes par le régime si elles continuent de résider au Nouveau-Brunswick.

Exception applicable aux employés temporaires : Les employés mobiles sont des résidents dont les conditions d'emploi nécessitent qu'ils voyagent fréquemment à l'extérieur de la province. Il faut respecter certaines conditions pour être désigné employé mobile :

- la demande doit être soumise par écrit;
- il faut fournir de la documentation pour prouver son statut d'employé mobile, c'est-à-dire, une lettre d'un employeur, une photocopie du permis d'immigration;
- la résidence permanente doit continuer d'être le Nouveau-Brunswick;
- il faut revenir au Nouveau-Brunswick pendant les périodes de temps libre.

La désignation d'employé mobile est assignée pour une période maximale de trois ans, après quoi le résident doit soumettre une nouvelle demande et fournir à nouveau la documentation pour confirmer son statut.

Une disposition spéciale assurant une couverture durant une période maximale de deux ans est prévue pour les enseignants du Nouveau-Brunswick qui sont employés en Louisiane.

L'assurance-maladie du Nouveau-Brunswick ne couvre, à l'extérieur du pays, que les services ambulatoires d'urgence, médicaux et hospitaliers, et les services aux malades hospitalisés qui en résultent. L'assurance-maladie paie les coûts des services médicaux associés aux interventions d'urgence au tarif en vigueur au Nouveau-Brunswick. Les frais d'établissements pour les coûts associés aux services médicaux sont payables en monnaie canadienne, c'est-à-dire, 100 $ par jour pour un malade hospitalisé et 50 $ par visite pour un malade externe.

L'assurance-maladie couvre les services fournis à l'étranger qui ne sont pas offerts au Canada, après approbation préalable seulement. Les résidents peuvent choisir d'obtenir, à l'étranger, des services non urgents; ceux qui reçoivent ces services assumeront toutefois la responsabilité de la totalité des coûts.

2000-2001		
Services fournis aux malades hospitalisés	**Services fournis aux malades externes**	**Services médicaux**
458 759 $	180 712 $	362 709 $

4.4 Nécessité d'une approbation préalable

Les résidents du Nouveau-Brunswick peuvent être admissibles au remboursement de services médicaux non urgents fournis à l'étranger s'ils remplissent certaines conditions :

- le ou les services nécessaires ne sont pas disponibles au Canada;
- ils sont fournis dans un hôpital figurant sur la liste de l'édition actuelle du *American Hospital Association Guide to the Health Care Field* (guide des hôpitaux des États-Unis, des systèmes de santé, des réseaux, des alliances, des organisations de santé, des agences et des fournisseurs de soins);
- ils sont fournis par un médecin en titre;
- ils constituent une méthode de traitement acceptée et reconnue par la communauté médicale et scientifiquement fondée – les procédures expérimentales ne sont pas couvertes.

Si les conditions susmentionnées sont remplies, il est obligatoire de demander, au préalable, une approbation au bureau de l'assurance-maladie pour bénéficier d'une couverture. Le médecin, le patient ou un membre de sa famille doit demander une approbation préalable pour recevoir ces services à l'étranger et fournir toute la documentation à l'appui.

Les deux services suivants font l'objet d'une exemption dans la politique de couverture à l'étranger:

- L'hémodialyse. Les patients doivent obtenir une approbation préalable, et l'assurance-maladie remboursera le résident à un tarif équivalent au tarif interprovincial.
- Les tests d'allergie pour la sensibilité aux substances présentes dans l'environnement. Tous les tests envoyés à l'extérieur du pays seront remboursés jusqu'à concurrence de 50 $ par jour, un montant équivalent au coût d'une visite de malade externe.

Une approbation préalable est également nécessaire pour l'aiguillage des patients vers des hôpitaux et des centres psychiatriques situés à l'extérieur de la province, car ces établissements sont exclus de l'entente de facturation réciproque. Une demande d'approbation préalable doit être envoyée par le médecin traitant.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Puisqu'il n'existe aucun ticket modérateur au Nouveau-Brunswick, tous les résidents ont un accès égal aux services de santé assurés.

5.2 Accès aux services hospitaliers assurés

Le plan directeur du réseau hospitalier du Nouveau-Brunswick détermine le nombre de lits approuvés par corporation hospitalière régionale. Dans le tableau 1 ci-dessous, on indique le nombre de lits approuvés.

Tableau 1 : Nombre total de lits approuvés, mars 2001

Type de lit		Nombre	Pourcentage
Non tertiaire	Soins actifs	2 878	72 %
	Soins analeptiques	397	10 %
	Toxicomanie	174	4 %
	CORCAN	2	0 %
	Anciens Combattants Canada	187	5 %
	Somme partielle	3 638	91 %
Tertiaire	Oncologie	80	2 %
	Chirurgie cardiaque	26	1 %
	Neurochirurgie	46	1 %
	Psychiatrie tertiaire	206	5 %
	Réadaptation tertiaire	20	0 %
	Somme partielle	378	9 %
Total pour la province		4 016	100 %

Tous les établissements qui dispensent des services assurés en vertu de la *Loi canadienne sur la santé* possèdent l'équipement ou les systèmes médicaux, chirurgicaux, de réadaptation et de diagnostic correspondants au niveau de soin désigné. Au 31 mars 2001, la province était équipée de neuf tomodensitomètres, un pour chacune des huit corporations hospitalières régionales et une unité supplémentaire pour la corporation des sciences de la santé de l'Atlantique (région 2). La province possèdait également deux appareils d'imagerie par résonnance magnétique mobiles de même qu'un système par résonnance magnétique à un endroit fixe.

Au cours de l'exercice 2000-2001, on a mis en oeuvre les initiatives suivantes dans le but d'améliorer l'accès aux services hospitaliers assurés au Nouveau-Brunswick :

- introduction d'un système d'IRM à un endroit fixe dans la corporation hospitalière régionale 1 (Sud-est);
- Médecine familiale a ouvert une « unité de dépannage » afin de réduire la saturation d'IU pendant la saison froide où il y a beaucoup de cas de grippes à la corporation hospitalière régionale 2;
- élargissement du service de dialyse rénale à la corporation hospitalière régionale 3;
- utilisation plus large et perfectionnement de la télésanté afin d'améliorer l'accès aux services dans plusieurs secteurs de programme à la corporation hospitalière régionale 3;
- la corporation hospitalière régionale 6 a accordé une plus grande importance à la télémédecine dans les programmes destinés aux patients;
- la corporation hospitalière régionale 6 a mis sur pied une clinique d'anticoagulothérapie;
- le ministère de la Santé et du Mieux-être a créé des mesures d'incitation financière afin de recruter et de maintenir en poste des radiothérapeutes, des technologues en radiation médicale (TRM) ainsi que des dosimétristes participant à la prestation de services de radiothérapie dans les centres de traitement du cancer.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Au total, 645 médecins de famille, 710 spécialistes, 9 dentistes ainsi que 5 chirurgiens stomatologistes offraient des services au Nouveau-Brunswick pendant l'exercice 2000-2001.

Pendant l'exercice 2000-2001, le Ministère a mis en oeuvre une stratégie de recrutement et de maintien en poste qui avait été annoncée en 1999-2000 et qui a pour but d'attirer de nouveaux médecins de famille et des spécialistes nouvellement autorisés. Cette stratégie comportait notamment l'établissement d'un fonds d'urgence visant à permettre au Ministère de mieux exploiter les possibilités de recrutement, par la création de primes d'emplacement de 25 000 $ pour les médecins de famille et de 40 000 $ pour les spécialistes qui souhaitent exercer leur profession dans des régions où le recrutement est difficile; par la création de dix places supplémentaires à la faculté de médecine de l'Université Memorial, l'accroissement de l'engagement du gouvernement à l'égard des études supérieures des médecins de famille de 12 à 30 et la hausse de la rémunération des médecins afin de réaliser la parité avec les autres provinces de l'Atlantique.

5.4 Rémunération des médecins

Un comité d'arbitrage a accordé aux médecins du Nouveau-Brunswick une augmentation de 10 p. 100 pour l'exercice 2000-2001 et de 8 p. 100 pour l'exercice 2001-2002. La répartition des augmentations de salaires est terminée. Toutefois, des discussions se poursuivent toujours afin de régler les questions qui n'ont pas été traitées par le comité d'arbitrage.

La Loi prévoit un mécanisme de règlement des différends qui comprend la médiation et l'arbitrage exécutoire.

Aucun processus de négociation officiel n'est prévu pour les dentistes.

Les Règlements 84-20, 93-143 et 96-113 de la *Loi sur le paiement des services médicaux* régissent les paiements aux médecins et aux dentistes.

Au Nouveau-Brunswick, les modes de rémunération des médecins pour la prestation de services de santé assurés sont multiples : rémunération à l'acte, salaire, rémunération à la séance ou autres modes de rémunération qui peuvent éventuellement être mixtes.

5.5 Paiements aux hôpitaux

Les principales lois qui régissent les paiements aux établissements hospitaliers au Nouveau-Brunswick sont la *Loi hospitalière*, qui régit l'administration des hôpitaux et la *Loi sur les services hospitaliers*, qui régit leur financement.

Au cours de l'exercice 2000-2001, aucune modification n'a été apportée au processus de paiement aux hôpitaux.

Le Ministère utilise deux éléments de la Loi pour distribuer les fonds disponibles aux corporations hospitalières régionales.

1) Le principal élément se fonde sur le « niveau de service actuel ». Il vise cinq services de soins aux patients :

   - les services tertiaires (cardiologie, dialyse, oncologie);
   - les services psychiatriques (unités et établissements psychiatriques);
   - les programmes spécialisés (p. ex., services de toxicomanie);
   - les services communautaires (programmes extra-muraux, centres de santé);
   - les soins généraux aux malades.

   S'ajoutent à ces services des services de soutien qui ne concernent pas les soins aux malades (p. ex. administration générale, buanderie, alimentation, alimentation en énergie, etc.).

   L'approche axée sur le niveau de service actuel établit des budgets de base pour les huit corporations hospitalières régionales pour les programmes et services susmentionnés. Ces budgets sont assortis de mesures pour les volumes de population et de services. Les budgets de base sont ensuite redressés chaque année afin de tenir compte de l'inflation et d'autres facteurs tels que les salaires de base négociés à l'échelle de la province.

2) Pendant l'exercice 2000-2001, on a amélioré la formule de répartition des fonds fondée sur la population. Cette méthode vise à prévoir la répartition appropriée des fonds disponibles pour les corporations hospitalières régionales selon les caractéristiques démographiques de la population et les parts de marché que représentent les volumes de patients, les cas étant mesurés par pondération du volume des ressources. À l'heure actuelle, cette méthode convient mieux aux volumes de malades hospitalisés en raison de l'absence de méthodes de répartition par groupes et de pondération applicables aux volumes de malades externes, notamment pour les services ambulatoires externes tels que l'oncologie et l'hémodialyse.

Le processus budgétaire actuel peut s'étendre sur plus d'un exercice et comporter plusieurs étapes. Chaque année, au mois de janvier, les corporations hospitalières régionales fournissent au Ministère leurs données touchant l'utilisation ainsi que leurs projections quant aux recettes pour l'année financière suivante; elles fournissent également leurs données touchant l'utilisation réelle et leurs données quant aux recettes pour les neufs premiers mois de l'exercice en cours. Ces chiffres, ainsi que les états financiers vérifiés des deux années précédentes, permettent d'évaluer les niveaux de financement prévus pour chaque corporation hospitalière régionale.

Des modifications sont apportées au budget pendant l'année afin de permettre certains rajustements des programmes et services pertinents, de façon récurrente ou non. Le processus de règlement de fin d'exercice permet de rapprocher le budget annuel total approuvé pour chaque corporation hospitalière

régionale en fonction de ses états financiers vérifiés, ainsi que des revenus et dépenses budgétés par rapport aux recettes et dépenses réelles.

6.0 Reconnaissance accordée aux transferts fédéraux

La province reconnaît invariablement le rôle du gouvernement fédéral en ce qui a trait aux contributions versées dans le cadre du Transfert canadien en matière de santé et de programmes sociaux, par l'intermédiaire des documents publics présentés au cours des processus législatifs ou administratifs. En font notamment partie les documents suivants :

- les Documents budgétaires présentés par le ministre des Finances le 27 mars 2001;
- les Comptes publics présentés par le ministre des Finances le 7 décembre 2000;
- le Budget principal des dépenses présenté par le ministre des Finances du Nouveau-Brunswick en mars 2001.

Le Nouveau-Brunswick ne produit pas de documents de promotion sur ses prestations d'assurance-maladie ou d'assurance hospitalisation.

7.0 Services complémentaires de santé

Le Programme de soins de longue durée du Nouveau-Brunswick, un service non assuré, a été transféré au Ministère des Services familiaux et communautaires le 1er avril 2000. Les soins en foyers de soins infirmiers sont dispensés dans le cadre du Programme des Services de foyers de soins du Ministère des Services familiaux et communautaires. D'autres services en établissement sont offerts par diverses agences et sont assurés grâce à d'autres sources de financement.

Services résidentiels et complémentaires

Dans le tableau 2 ci-dessous, on trouve la liste des services en établissements et les services de soins prolongés offerts au Nouveau-Brunswick au 31 mars 2001. Les foyers de soins sont des organismes privés sans but lucratif, à l'exception d'un seul qui est la propriété de la province. Pour y être admis, les clients doivent se soumettre à un processus d'évaluation fondé sur des critères précis touchant leur état de santé.

Les établissements résidentiels pour adultes sont, pour la plupart, des établissements privés à but lucratif. Le nombre de lits disponibles varie constamment avec l'ouverture ou la fermeture de résidences par les propriétaires. Les clients y sont admis après avoir subi le même processus d'évaluation que dans les foyers de soins infirmiers.

Les logements subventionnés sont réservés aux personnes âgées à faible revenu. Les critères d'admission sont exclusivement fondés sur l'âge et sur la situation financière des clients. Les Infirmières de l'Ordre de Victoria du Canada offrent des services dans certaines unités.

Tableau 2 : Disponibilité des soins résidentiels et complémentaires

Services	Nombre d'unités ou de lits
Lits en foyers de soins	4 140
Établissements résidentiels pour adultes* (lits)	5 341
Logements subventionnés (unités)	2 088
Total pour la province	11 569

* Comprend les foyers de soins spéciaux et les résidences communautaires.

Soins ambulatoires

Au Nouveau-Brunswick, les soins ambulatoires comprennent des soins dispensés dans les salles d'urgences des hôpitaux, des soins de jour et de nuit fournis à l'hôpital et des

soins cliniques pour autant qu'ils soient offerts dans les établissements hospitaliers et les centres de santé. Selon le régime de services hospitaliers, ce service est un service assuré.

Programme extra-mural

Le Programme extra-mural du Nouveau-Brunswick, également désigné sous le nom d'hôpital à la maison, est un programme de traitement actif dans le cadre duquel des soins actifs, des soins palliatifs et des soins de longue durée sont dispensés dans la collectivité, par exemple, à domicile, dans des foyers de soins ou dans des écoles publiques. Depuis 1996, les huit corporations hospitalières régionales se sont chargées de la mise en oeuvre du Programme extra-mural. Parmi les fournisseurs de soins, mentionnons des infirmières, des travailleuses sociales, des diététistes, des inhalothérapeutes, des physiothérapeutes, des ergothérapeutes et des orthophonistes. Le service est considéré comme un service assuré par le régime de services hospitaliers.

Annexe 1 : Établissements hospitaliers du Nouveau-Brunswick, septembre 2001

Corporation hospitalière	Établissements dispensant des services de santé assurés *(emplacement)*	Autres établissements / centres de santé *(emplacement)*
Corporation hospitalière régionale 1 (sud-est) Corporation de soins de santé sud-est	The Albert County Hospital Inc. *(Albert)* The Moncton Hospital *(Moncton)* The Sackville Memorial Hospital *(Sackville)*	Centre de santé Petitcodiac *(Petitcodiac)* Services de santé, Rexton *(Rexton)*
Corporation hospitalière régionale 1 (Beauséjour) Corporation Hospitalière Beauséjour	Hôpital Docteur Georges L. Dumont *(Moncton)* L'Hôpital Stella Maris de Kent *(Sainte-Anne-de-Kent)*	Centre médical régional de Shédiac (Shédiac)
Corporation hospitalière régionale 2 Corporation des sciences de la santé de l'Atlantique	Saint John Regional Hospital Facility *(Saint John)* The Charlotte County Hospital Facility *(St. Stephen)* Établissement du Centre de santé Sussex *(Sussex)* Établissement hospitalier St- Joseph *(Saint John)* The Grand Manan Hospital Limited Facility *(Grand Manan Island)* Centracare Saint John Inc. * *(Saint John)*	Établissement du centre de santé Campobello *(Campobello Island)* Établissement du centre de santé Deer Island *(Deer Island)* Établissement limité de l'association des hôpitaux de Fundy *(Black's Harbour)*
Corporation hospitalière régionale 3	Northern Carleton Hospital *(Bath)* Queens North Health Complex *(Minto)* Oromocto Public Hospital *(Oromocto)* L'Hôtel-Dieu Saint-Joseph de Perth-Andover Inc. *(Perth-Andover)* Dr. Everett Chalmers Hospital *(Fredericton)* The Tobique Valley Hospital *(Plaster Rock)* Stan Cassidy Centre for Rehabilitation * *(Fredericton)* The Carleton Memorial Hospital *(Woodstock)*	MacLean Memorial Hospital *(McAdam)* Chipman Health Services Centre *(Chipman)* Upper Miramichi Health Services Centre *(Doaktown)* Upper Miramichi Health Services Centre *(Boiestown)* Stanley Health Services Centre *(Stanley)* Fredericton Junction Health Services Centre *(Fredericton Junction)* Harvey Community Hospital *(Harvey Station)*
Corporation hospitalière régionale 4	L'Hôpital régional d'Edmundston *(Edmundston)* Grand Falls General Hospital Inc. *(Grand Falls)* L'Hôtel-Dieu Saint Joseph de Saint-Quentin Inc. *(Saint-Quentin)*	Centre de Santé de Ste- Anne de Madawaska *(Sainte-Anne-de-Madawaska)*
Corporation hospitalière régionale 5	L'Hôpital régional de Campbellton *(Campbellton)* Restigouche Hospital Centre Inc. *(Campbellton)* L'Hôpital St. Joseph de Dalhousie *(Dalhousie)*	Centre de santé de Jacquet- River *(Belledune)*
Corporation hospitalière régionale 6 Réseau Santé NOR'EST / NOR'EAST Health Network	L'Hôpital régional Chaleur *(Bathurst)* Centre hospitalier de l'Enfant-Jésus inc. *(Caraquet)* Centre hospitalier de Lamèque *(Lamèque)* Centre hospitalier de Tracadie *(Tracadie)*	Centre de santé de Paquetville *(Paquetville)* Centre de santé de Chaleur *(Pointe Verte)*
Corporation hospitalière régionale 7	Miramichi Regional Facility *(Miramichi)*	Baie Ste- Anne Health Centre *(Baie Ste-Anne)* Centre de santé Neguac *(Neguac)* Centre de santé Blackville *(Blackville)* Centre de santé Rogersville *(Rogersville)*

Remarques :
1. Services de santé assurés sont définis dans la *Loi canadienne sur la santé*
2. * indique qu'il s'agit d'un centre tertiaire provincial
3. Les Services de la toxicomanie, les Unités des vétérans et les Unités du Programme extra-mural ne sont pas mentionnés dans cette liste

Québec

Énoncé du Québec

Dans le présent rapport, les renseignements relatifs au Québec sont présentés de la même manière que dans les précédents rapports annuels préparés par Santé Canada pour répondre, depuis l'adoption de la *Loi canadienne sur la santé*, aux exigences de cette législation.

Le gouvernement du Québec, en vertu de sa compétence constitutionnelle en matière de santé, rend des comptes à l'Assemblée nationale et aux citoyens québécois sur sa gestion des services de santé. À cette fin, il rend publics, de façon régulière, divers documents et rapports traitant, notamment, de l'état de santé de la population, de la satisfaction des patients et de l'organisation des services de santé et des services sociaux sur son territoire. La plupart de ces documents sont disponibles dans les sites Web du ministère de la Santé et des Services sociaux du Québec <www.msss.gouv.qc.ca> et de la Régie de l'assurance maladie du Québec <www.ramq.gouv.qc.ca>.

Réponse du gouvernement fédéral au Québec

Le ministre fédéral de la Santé doit rendre compte au Parlement et aux Canadiens de la manière dont il surveille la conformité à la *Loi canadienne sur la santé*. L'article 23 de la *Loi canadienne sur la santé* exige qu'un rapport annuel au Parlement soit établi, au plus tard le 31 décembre de chaque année, sur l'administration de cette loi au cours du précédent exercice. Ce rapport annuel doit inclure « [...] tous les renseignements pertinents sur la mesure dans laquelle les provinces ont satisfait aux conditions d'octroi et de versement prévues par la présente loi. » Pour remplir cette obligation statutaire, le ministre de la Santé doit obtenir l'information directement des régimes d'assurance-santé des provinces et des territoires.

En 1999, le vérificateur général du Canada a fait la recommandation suivante : « Dans ses rapports annuels au Parlement, Santé Canada devrait préciser dans quelle mesure les régimes d'assurance-santé provinciaux et territoriaux ont satisfait aux conditions d'octroi et de versement de la *Loi canadienne sur la santé*. Lorsque le Ministère n'inclut pas cette information dans ses rapports, il devrait expliquer clairement la raison de cette absence. » Pour faire suite à cette recommandation portant sur l'amélioration des activités de surveillance et d'application de la *Loi canadienne sur la santé*, Santé Canada, en collaboration avec les provinces et les territoires, a élaboré en 2000 et en 2001 une présentation normalisée pour le *Rapport annuel de la Loi canadienne sur la santé*. Il en a aussi élargi le contenu afin que les lecteurs puissent mieux déterminer la mesure dans laquelle les provinces et les territoires se conforment à cette loi.

Santé Canada a informé toutes les provinces et tous les territoires des modifications à apporter à la présentation et au contenu du rapport, dont l'ajout d'une annexe statistique permettant de situer dans un contexte quantitatif l'application de la *Loi canadienne sur la santé*. Le Ministère a offert aux autorités provinciales et territoriales soutien et conseils techniques pour la préparation de leurs documents en organisant de nombreuses téléconférences et réunions multilatérales. Toutes les provinces et tous les territoires, sauf le Québec, ont accepté d'apporter ces modifications.

Dans le cadre de la préparation du présent rapport annuel, le Québec a fourni certaines statistiques, présentées dans l'Annexe A – Statistiques des régimes provinciaux et territoriaux d'assurance-santé. Cependant, la nature et la ventilation des statistiques québécoises ne correspondent pas aux nouvelles exigences. Le gouvernement fédéral n'est pas convaincu que le Québec fournit suffisamment d'information pour permettre une évaluation efficace de la conformité de la province aux dispositions de la *Loi canadienne sur la santé* et l'application des recommandations du vérificateur général du Canada. Le gouvernement fédéral continuera à collaborer avec le Québec afin que cette information soit disponible et, par le fait même, qu'il puisse démontrer la conformité de la province à la *Loi*.

Québec

Gestion publique

Régimes d'assurance hospitalisation et de soins médicaux

Le régime d'assurance hospitalisation du Québec est géré par le ministère de la Santé et des Services sociaux.

Le régime d'assurance maladie du Québec est administré par la Régie de l'assurance maladie du Québec, organisme public établi par le gouvernement provincial et qui relève du ministre de la Santé et des Services sociaux. Les deux régimes sont gérés sans but lucratif, et tous les livres et comptes sont vérifiés par le Vérificateur général de la province.

Intégralité

Régime d'assurance hospitalisation

Le réseau d'établissements régi par le ministère de la Santé et des Services sociaux comprend les centres hospitaliers, certains centres d'hébergement et de soins de longue durée (anciens centres hospitaliers de soins de longue durée)[1] et les centres locaux de services communautaires (CLSC).

Le traitement des maladies physiques et mentales est assumé par les centres hospitaliers et par certains centres d'hébergement et de soins de longue durée.

Les services assurés aux malades hospitalisés sont dispensés dans les unités d'hospitalisation des centres hospitaliers, tandis que les services assurés de consultation externe sont principalement dispensés dans les centres d'hébergement et dans les CLSC.

Les services assurés aux malades hospitalisés comprennent : l'hébergement et les repas en salle commune; les soins infirmiers nécessaires; les fournitures chirurgicales courantes; les services de diagnostic; l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie; les médicaments; les prothèses et les orthèses pouvant être intégrées à l'organisme humain; les produits biologiques et les préparations connexes; l'usage des installations de radiothérapie, de radiologie et de physiothérapie; les services fournis par le personnel du centre hospitalier.

Les services de consultation externe comprennent : les services cliniques de soins psychiatriques; les soins en électrochocs, l'insulinothérapie et la thérapie du comportement; les soins d'urgence; les soins en chirurgie de moindre importance (chirurgie d'un jour); la radiothérapie; les services de diagnostic; la physiothérapie; l'ergothérapie; les services d'inhalothérapie, d'audiologie, d'orthophonie et d'orthoptique; d'autres services ou examens exigés par une loi du Québec.

D'autres services sont assurés : les services à des fins de contraception mécanique, hormonale ou chimique; les services de stérilisation chirurgicale, dont la ligature des trompes et la vasectomie; la réanastomose des trompes ou des canaux; l'ablation de dent ou de racine lorsque l'état de santé du bénéficiaire nécessite des services hospitaliers.

Le ministère de la Santé et des Services sociaux administre gratuitement un programme de transport par ambulance pour les personnes âgées de 65 ans ou plus.

Les services hospitaliers non assurés comprennent : la chirurgie plastique; la fécondation *in vitro*; l'hébergement en chambre privée ou semi-privée à la demande du patient; la télévision; le téléphone; les médicaments et les produits biologiques prescrits après le congé

[1] Depuis le 1er octobre 1992, les centres hospitaliers de soins de longue durée et les centres d'hébergement font partie d'une seule catégorie d'établissements (centres d'hébergement et de soins de longue durée—CHSLD) sans que leur mission spécifique ne soit modifiée pour autant.

du patient; les services auxquels le patient a droit en vertu de la *Loi sur les accidents du travail et les maladies professionnelles* ou d'autres lois fédérales ou provinciales.

Régime de soins médicaux

Les services assurés par ce régime comprennent : les services médicaux et chirurgicaux rendus par les médecins; les services de chirurgie buccale rendus dans un centre hospitalier ou un établissement universitaire déterminé par règlement, par les chirurgiens-dentistes et les spécialistes en chirurgie buccale et maxillo-faciale.

Les services suivants ne sont pas considérés comme assurés : tout examen ou service non relié à un processus de guérison ou de prévention de la maladie; la psychanalyse sous toutes ses formes, à moins que ce type de service ne soit rendu dans un établissement autorisé à cette fin par le ministre de la Santé et des Services sociaux; tout service dispensé à des fins purement esthétiques; toute chirurgie réfractive, sauf dans les cas où il y a eu échec documenté au port de verres correcteurs ou de lentilles cornéennes pour de l'astigmatisme de plus de 3,00 dioptries ou de l'anisométropie de plus de 5,00 dioptries, mesurées au plan cornéen; toute consultation par voie de télécommunication ou par correspondance; tout service rendu par un professionnel à son conjoint ou à ses enfants; tout examen, toute expertise, tout témoignage, tout certificat ou toute autre formalité lorsqu'ils sont requis aux fins de la justice ou par une personne autre que celle qui a reçu un service assuré, sauf dans certains cas; toute visite faite dans le seul but d'obtenir le renouvellement d'une ordonnance; tout examen, tout vaccin, toute immunisation et toute injection lorsque le service est rendu à un groupe ou fourni à certaines fins; tout service rendu par un professionnel sur la base d'une entente ou d'un contrat avec un employeur, une association ou un organisme; tout ajustement de lunettes ou de lentilles cornéennes; toute ablation chirurgicale d'une dent ou d'un fragment dentaire faite par un médecin, à moins qu'un tel service ne soit rendu dans un centre hospitalier dans certains cas; tous les actes d'acupuncture; l'injection de substances sclérosantes et l'examen dispensé à cette occasion; la thermographie, la mammographie utilisée à des fins de dépistage, à moins que ce service ne soit rendu dans un lieu désigné par le Ministre dans l'un ou l'autre des cas, soit à une bénéficiaire âgée de 40 ans ou plus et de moins de 50 ans présentant un facteur de risque important associé au cancer du sein et à la condition qu'un tel examen n'ait pas été subi par cette bénéficiaire depuis deux ans, ou encore à une bénéficiaire âgée de 50 ans ou plus à la condition qu'un tel examen n'ait pas été subi par cette bénéficiaire depuis deux ans; la tomodensitométrie, l'imagerie par résonance magnétique, l'usage des radionucléides *in vivo* chez l'humain et l'ultrasonographie, à moins que ces services ne soient rendus dans un centre hospitalier; tout service de radiologie ou d'anesthésie rendu par un médecin, s'il est requis en vue de dispenser un service non assuré, à l'exception d'un service dentaire rendu dans un centre hospitalier, ou dans le cas d'un service de radiologie, s'il est requis par une personne autre qu'un médecin ou un dentiste; tout service de chirurgie transsexuelle, à moins qu'il ne soit rendu sur recommandation d'un médecin spécialiste en psychiatrie et dans un centre hospitalier reconnu à cet effet; tout service qui n'est pas associé à une pathologie et qui est rendu par un médecin à un bénéficiaire ayant entre 18 et 65 ans, à moins que ce bénéficiaire ne détienne un carnet de réclamation, pour un problème de daltonisme ou de réfraction, dans le but d'obtenir ou de renouveler une ordonnance pour des lunettes ou des lentilles cornéennes.

En plus des services de santé assurés de base, la Régie couvre également, avec des restrictions pour certains habitants du Québec au sens de la *Loi sur l'assurance maladie* et les prestataires d'assistance-emploi, les services optométriques; les services dentaires pour les enfants et les prestataires d'assistance-emploi, et les prothèses dentaires acryliques pour les prestataires d'assistance-emploi; les prothèses, les appareils orthopédiques, les aides à la locomotion et à la posture, et les autres équipements qui suppléent à une déficience physique; les prothèses mammaires externes; les prothèses oculaires; les aides auditives, les aides de suppléance à l'audition et les aides visuelles pour les personnes ayant un handicap auditif ou visuel; les appareils fournis aux stomisés permanents.

Par ailleurs, en matière d'assurance médicaments, depuis le 1er janvier 1997, la Régie couvre, outre sa clientèle habituelle (prestataires d'assistance-emploi et personnes âgées de 65 ans ou plus), les personnes qui autrement n'auraient pas accès à un régime privé d'assurance-médicaments. Le nouveau régime d'assurance médicaments couvre 3,2 millions de personnes assurées.

Universalité

Régimes d'assurance hospitalisation et de soins médicaux

L'inscription à l'assurance hospitalisation n'est pas nécessaire; il suffit d'être inscrit à la Régie de l'assurance maladie ou de fournir une preuve de résidence pour établir l'admissibilité. Toute personne qui réside ou est réputée résider au Québec doit être inscrite à la Régie de l'assurance maladie pour être admissible aux programmes d'assurance maladie. Les services reçus par les membres réguliers des Forces canadiennes, les membres de la Gendarmerie royale du Canada et les détenus des pénitenciers fédéraux ne sont pas assurés par le régime. Aucune prime n'est perçue.

Transférabilité

Régimes d'assurance hospitalisation et de soins médicaux

Délai minimal de résidence

Une personne qui s'établit au Québec après avoir quitté une province canadienne devient bénéficiaire du régime d'assurance maladie du Québec lorsqu'elle cesse d'avoir droit aux bénéfices de la province d'origine, pour autant qu'elle s'inscrive à la Régie.

Lorsqu'ils séjournent 183 jours ou plus à l'extérieur du Québec, les étudiants et les stagiaires à temps complet et sans rémunération peuvent conserver leur statut de résidant du Québec dans le premier cas pendant au plus quatre années civiles consécutives et dans le deuxième cas, pendant au plus deux années civiles consécutives. Les fonctionnaires du gouvernement du Québec, les employés d'un organisme sans but lucratif dont le siège social est au Canada et qui travaillent à l'étranger dans un programme d'aide ou de coopération reconnu par le ministre de la Santé et des Services sociaux ainsi que les conjoints et les personnes à charge de l'une ou l'autre de ces personnes maintiennent leur statut d'habitant de la province pourvu qu'ils avisent la Régie de leur absence.

Il en est de même pour les personnes qui séjournent dans une autre province pour y chercher ou y occuper un emploi temporaire ou exécuter un contrat alors que leur famille demeure au Québec ou qu'elles y conservent une résidence. Leur statut de résidant peut être conservé pendant au plus deux années civiles consécutives.

Les personnes qui occupent un emploi ou exécutent un contrat hors du Québec pour le compte d'une société dont le siège social est au Québec ou qui sont à l'emploi du gouvernement fédéral et en service hors du Québec maintiennent également leur statut d'habitant de la province pourvu que leur famille demeure au Québec ou qu'elles y conservent une résidence.

Maintiennent également leur statut d'habitant de la province les personnes qui séjournent à l'extérieur 183 jours ou plus sans excéder 12 mois au cours d'une même année civile, à condition que cette absence n'ait lieu qu'une fois tous les sept ans et pourvu qu'elles en avisent la Régie.

Certaines catégories de résidants, notamment les résidants permanents au sens de la *Loi sur l'immigration*, les Canadiens rapatriés et ceux qui s'établissent à nouveau au Canada, les membres des Forces canadiennes ou de la Gendarmerie royale du Canada qui n'ont pas acquis la qualité d'habitants du Québec et les détenus des pénitenciers fédéraux, deviennent bénéficiaires dès le premier jour de leur arrivée, de leur élargissement ou de leur libération. Une couverture immédiate est également fournie

aux ressortissants étrangers qui détiennent un permis de travail et qui séjournent au Québec pour y occuper une charge ou un emploi pour une période de trois mois ou plus ou qui y séjournent en vertu d'un programme officiel de bourses d'études ou de stages du ministère de l'Éducation.

Paiement des services dispensés au Canada

Les coûts des services hospitaliers reçus par un bénéficiaire dans une autre province ou un territoire sont remboursés selon les termes de l'accord interprovincial de facturation réciproque en matière d'assurance-hospitalisation, convenu entre les provinces et territoires du Canada. Ces coûts sont remboursés soit au taux établi pour l'hospitalisation en salle et approuvé par la province d'accueil, ou au tarif interprovincial approuvé s'il s'agit de services de consultation externe ou d'intervention coûteux. Toutefois, depuis le 1er novembre 1995, lorsqu'un habitant de l'Outaouais est hospitalisé dans un centre universitaire d'Ottawa pour des soins non urgents ou des services offerts dans l'Outaouais, le gouvernement du Québec paie l'hôpital ontarien au tarif moyen des centres spécialisés de l'Outaouais.

Les coûts des services médicaux reçus par un bénéficiaire dans une autre province ou un territoire sont remboursés au moindre montant, soit le montant effectivement payé ou celui qui aurait été payé par la Régie pour de tels services au Québec. Cependant, le Québec a négocié une entente permanente avec l'Ontario de façon à ce que les médecins d'Ottawa soient rémunérés selon le barème ontarien lorsqu'ils dispensent des soins en cas d'urgence et lorsque les services spécialisés fournis ne sont pas offerts dans la région de l'Outaouais. Cette entente est entrée en vigueur le 1er novembre 1989. Une entente semblable a été signée en décembre 1991 pour la région de l'Abitibi-Témiscamingue et de North Bay.

Paiement des services dispensés à l'étranger

Depuis le 1er septembre 1996, les services hospitaliers dispensés à l'extérieur du Canada en situation d'urgence ou de maladie subite sont remboursés par la Régie, généralement en dollars canadiens, jusqu'à concurrence de 100 $CAN par jour s'il y a eu hospitalisation, y compris dans le cas d'une chirurgie d'un jour, ou de 50 $ par jour pour les soins dispensés sur une base externe.

Toutefois, les traitements d'hémodialyse sont payés jusqu'à concurrence de 220 $ par traitement. Dans ces cas, la Régie rembourse les services professionnels associés. Les services doivent être dispensés dans un hôpital ou un centre hospitalier reconnu et agréé par les autorités compétentes. Aucun remboursement n'est effectué pour des maisons de repos, des stations thermales ou d'autres endroits analogues.

Les étudiants, les stagiaires non rémunérés, les fonctionnaires québécois en poste à l'étranger, les missionnaires et les employés d'un organisme sans but lucratif œuvrant dans le cadre d'un programme d'aide ou de coopération internationale reconnu par le ministère de la Santé et des Services sociaux doivent communiquer avec la Régie pour déterminer leur admissibilité. Si la Régie leur reconnaît un statut particulier, ils sont remboursés en totalité pour les frais hospitaliers en cas d'urgence ou de maladie subite et à 75 p. 100 dans les autres cas.

Les services assurés rendus par les médecins, les dentistes, les chirurgiens buccodentaires et les optométristes sont remboursés au tarif qui aurait été payé par la Régie à un professionnel de la santé reconnu du Québec, jusqu'à concurrence des frais réellement assumés. Tous les services assurés dans la province sont remboursés au tarif du Québec, habituellement en dollars canadiens, lorsqu'ils sont dispensés à l'étranger.

Les bénéficiaires qui doivent recevoir à l'étranger des services médicaux en milieu hospitalier qui ne sont pas offerts au Québec ou au Canada sont remboursés à 100 p. 100 avec autorisation préalable pour les services médicaux et hospitaliers répondant à certaines conditions. Les responsables du régime n'accordent pas leur consentement si le service hospitalier en question est offert au Québec ou au Canada.

Déménagement permanent à l'extérieur de la province

Une personne assurée qui quitte le Québec pour s'établir dans une autre province du Canada demeure bénéficiaire jusqu'à concurrence de trois mois après son départ.

Une personne assurée qui quitte le Québec pour s'établir en permanence dans un autre pays cesse, dès le jour de son départ, d'être bénéficiaire.

Accessibilité

Régimes d'assurance hospitalisation et de soins médicaux

Accès raisonnable

Toute personne a le droit de recevoir des services de santé adéquats sans discrimination d'aucune sorte.

Les médecins québécois ne pratiquent pas la surfacturation. La plupart des médecins exercent leur profession en conformité avec le régime provincial, mais le Québec permet deux autres options : celle des professionnels désengagés qui exercent leur profession en dehors des cadres du régime, mais qui acceptent d'être rémunérés suivant le tarif prévu par l'entente provinciale, et celle des professionnels non participants qui exercent leur profession en dehors des cadres du régime, de sorte que ni eux ni leurs patients ne reçoivent de remboursement de la Régie.

Au 31 mars 2001, le Québec comptait 125 établissements ayant une mission de centre hospitalier pour une clientèle souffrant de maladie aiguë. À la même date, on comptait 21 804 lits de soins physiques et psychiatriques de courte durée, au permis de ces établissements. Par ailleurs, dans les établissements hospitaliers du Québec, il y eu entre le 1er avril 1999 et le 31mars 2000[2]pries de 736 500 admissions pour des séjours de courte durée et près de 78 000 inscriptions en chirurgie d'un jour. Ces hospitalisations et inscriptions ont représenté 5 555 738 jours d'hospitalisation.

Paiements aux centres hospitaliers

Le financement d'un centre hospitalier par le ministère de la Santé et des Services sociaux s'effectue par l'entremise de paiements en rapport avec le coût des services assurés fournis.

Les paiements versés en 1999-2000[2] aux établissements ayant mission de centre hospitalier pour les services de santé assurés fournis aux habitants du Québec se sont élevés à environ 5,5 milliards de dollars, et les paiements versés aux centres hospitaliers de l'extérieur se sont élevés à environ 73 363 000 $.

Mode de paiement des soins médicaux

Les médecins sont rémunérés selon les tarifs prévus et négociés. Les médecins désengagés sont rémunérés directement par le patient selon le barème des honoraires après que celui-ci a été payé par la Régie. Les médecins non participants sont rémunérés directement par le patient selon le tarif exigé.

Rémunération raisonnable

La rémunération raisonnable pour tous les services de santé assurés dispensés par les professionnels de la santé est établie par la loi. Le Ministre peut conclure une entente avec les organismes représentatifs de toute catégorie de professionnels de la santé. Cette entente peut prévoir un taux de rémunération différent pour la fourniture des services médicaux dans un territoire où les effectifs de la santé sont considérés comme insuffisants. Le Ministre peut aussi prévoir un taux de rémunération différent pour les médecins omnipraticiens et les médecins spécialistes durant les premières années d'exercice selon le territoire ou l'activité en cause. Ces dispositions font suite à la consultation menée auprès des organismes représentatifs des groupes professionnels.

En 2000-2001, la Régie a versé un montant évalué à 2 553,1 millions de dollars aux médecins de la province, alors que le montant évalué pour les services médicaux hors de la province s'élevait à 8,9 millions de dollars.

[2] La dernière année pour laquelle ces données sont disponibles.

Services complémentaires de santé

Des soins intermédiaires, des soins aux adultes en établissement et des soins à domicile sont offerts. Les admissions sont coordonnées à l'échelle régionale et sont fondées sur un outil d'évaluation unique. Les CLSC reçoivent les candidats, évaluent leurs besoins en matière de santé et prennent des dispositions en vue de la prestation de services, comme les programmes de centre de jour ou les soins à domicile, ou orientent ces personnes vers les organismes appropriés.

Le ministère de la Santé et des Services sociaux offre certains services de soins à domicile qui comprennent les services de soins infirmiers et d'aide, les services d'aides familiales et la surveillance médicale.

Les résidences, de même que les unités de soins prolongés des hôpitaux de soins de courte durée, mettent l'accent sur le maintien de l'autonomie et des capacités fonctionnelles de leurs clients en leur fournissant toute une gamme de programmes et de services, y compris des soins de santé.

Ontario

Introduction

Le ministère de la Santé et des Soins de longue durée de l'Ontario a pour responsabilité d'administrer le système de soins de santé de la province et de fournir des services au public ontarien par l'entremise de programmes tels que le régime d'assurance-santé, le régime d'assurance-médicaments, des appareils et des accessoires fonctionnels, des soins aux personnes souffrant de troubles psychiques, des soins de longue durée, des services de soins à domicile, des services de santé communautaire et publique, des services de promotion de la santé et de prévention des maladies. Le ministère est également responsable de la réglementation touchant les hôpitaux, les établissements de soins infirmiers et de longue durée; gère les hôpitaux psychiatriques et les laboratoires médicaux et coordonne les services de santé d'urgence.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le régime d'assurance-santé de l'Ontario (OHIP) est établi en vertu de la *Loi sur l'assurance-santé* (Lois refondues de l'Ontario, 1990, c. H-6) pour offrir une assurance sur les coûts des services assurés offerts dans les hôpitaux et les établissements de santé et par les médecins et les autres professionnels de la santé. Le régime d'assurance-santé est sans but lucratif et il est géré par le ministère de la Santé et des Soins de longue durée (voir l'article 10 de la *Loi sur l'assurance-santé*).

1.2 Liens hiérarchiques

Le régime d'assurance-santé de l'Ontario fait partie du ministère de la Santé et des Soins de longue durée de l'Ontario. Ses rapports sur ses activités et ses opérations sont inclus aux publications générales du ministère, y compris le plan d'activités annuel du ministère.

1.3 Vérification des comptes

Les comptes et les transactions du régime d'assurance-santé de l'Ontario sont vérifiés par le vérificateur provincial et publiés annuellement dans les Comptes publics de l'Ontario.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les services hospitaliers assurés sont régis, en Ontario, par la *Loi sur l'assurance-santé* et son Règlement 552. La loi et le règlement définissent les services assurés à l'égard des malades hospitalisés et des malades externes.

Les services assurés fournis aux malades hospitalisés comprennent :

- l'hébergement dans une unité de soins commune et les repas;
- les services infirmiers nécessaires;
- les procédures de laboratoire, de radiologie et les autres procédures de diagnostic;
- les médicaments, les préparations biologiques et les préparations connexes;
- l'utilisation des salles d'opération, des salles d'accouchement et des facilités anesthésiques.

Les services assurés fournis aux malades externes comprennent :

- les procédures de laboratoire, de radiologie et les autres procédures de diagnostic;
- l'utilisation des installations de radiothérapie, de ergothérapie, de physiothérapie et d'orthophonie, là où elles sont disponibles;
- l'utilisation des services de conseil diététique;

- l'utilisation de l'équipement, des fournitures et de la médication associés à la dialyse rénale à domicile et à la suralimentation à domicile;
- l'équipement, les fournitures et la médication fournis aux patients hémophiles pour usage à la maison;
- la cyclosporine fournie aux patients greffés;
- la zidovudine, la didanosine, la zalcitabine et la pentamidine fournies aux patients infectés par le VIH;
- les hormones de croissance humaines biosynthétiques fournies aux patients souffrant de déficience en hormones de croissance endogènes;
- les médicaments destinés au traitement de la fibrose kystique et de la thalassémie;
- l'érythropoïétine fournie aux patients souffrant d'anémie à la phase terminale d'une maladie rénale;
- l'alglucérase administrée aux patients souffrant de la maladie de Gaucher;
- la clozapine fournie aux patients souffrant d'une forme de schizophrénie résistante au traitement;
- l'administration d'un vaccin antirabique.

Outre les services hospitaliers assurés, l'Ontario offre des services de longue durée, des services de santé mentale, dont l'exploitation d'hôpitaux psychiatriques provinciaux, l'élément résidentiel du Programme des foyers de soins spéciaux, les services d'ambulanciers (par voie aérienne et terrestre) dotés d'un élément de co-paiement par le patient, les traitements dentaires pour les patients souffrant d'une fissure labiale et/ou d'une fente palatine inscrits à une clinique désignée, et le financement pour un Programme de dépistage du cancer du sein.

Les hôpitaux publics de l'Ontario sont soumis à la *Loi sur les hôpitaux publics*, laquelle comprend le Règlement 964 sur la classification des hôpitaux et le Règlement 965 sur la gestion des hôpitaux.

En 2000-2001, il y avait 155 hôpitaux publics (excluant les hôpitaux spécialisés, les hôpitaux privés, les hôpitaux psychiatriques provinciaux, les hôpitaux fédéraux et les maisons de soins infirmiers) en opération dans la province. Ils comprennent 140 hôpitaux de soins actifs, 11 hôpitaux pour malades chroniques et 4 unités de réadaptation générale et spécialisée. Les établissements sont catégorisés par activité principale, même s'ils offrent divers services hospitaliers. Par exemple, bon nombre d'hôpitaux de soins actifs offrent des services de soins pour malades chroniques, tout comme bon nombre d'établissements pour malades chroniques offrent aussi des services de réadaptation. Les hôpitaux publics peuvent être agréés par le Conseil canadien d'agrément des services de santé (CCASS).

Lorsque des services médicaux assurés sont fournis dans les installations agréées autres que les hôpitaux, et lorsque les coûts totaux des services assurés ne sont pas inclus dans les frais médicaux payés en vertu de la *Loi sur l'assurance-santé*, le ministère de la Santé et des Soins de longue durée de l'Ontario offre un financement des frais d'établissement en vertu de la *Loi sur les établissements de santé autonomes*. Les frais d'établissement comprennent le coût des installations, de l'équipement, des fournitures et du personnel utilisé pour offrir un service assuré, lorsque ces coûts ne sont pas inclus dans les frais du médecin. En vertu de la *Loi sur les établissements de santé autonomes*, les frais d'établissement aux patients sont interdits.

Les établissements agréés en vertu de la *Loi sur les établissements de santé autonomes* ne peuvent facturer les frais d'établissement qu'au gouvernement. Ces établissements agréés comprennent des établissements de traitement et de chirurgie (où se font des avortements, des chirurgies de la cataracte, des dialyses, des chirurgies plastiques, etc.) et des établissements de diagnostic (où l'on offre des services de radiographie, d'ultrasons, de médecine nucléaire, des études du sommeil et des études fonctionnelles respiratoires). Les nouveaux établissements sont habituellement fondés à la suite d'un processus de demandes de propositions basé sur une évaluation du besoin envers le service en question.

2.2 Services médicaux assurés

En vertu de l'article 37(1) du Règlement 552 de la *Loi sur l'assurance-santé*, un service rendu par un médecin en Ontario est assuré s'il est médicalement nécessaire, inclus dans le barème des prestations et est fourni dans des circonstances ou conditions spécifiées dans le barème des prestations.

L'Ordre des médecins et chirurgiens de l'Ontario est l'organisme qui autorise les médecins à pratiquer la médecine en Ontario. Environ 20 700 médecins inscrits peuvent soumettre des réclamations au régime d'assurance-santé de l'Ontario.

Les médecins peuvent soumettre les réclamations directement au régime d'assurance-santé de l'Ontario pour tous les services assurés fournis à des personnes assurées ou, encore, ils peuvent facturer directement la personne assurée (le patient) pour tous les services assurés tel qu'énoncé à l'article 15 de la *Loi sur l'assurance-santé* (voir également la *Loi sur l'accessibilité aux services de santé*). Les médecins qui ne facturent pas directement le régime d'assurance-santé de l'Ontario sont habituellement désignés comme « exclus ». Un médecin exclu facture le patient (pas plus que le montant payable pour le service selon le barème des prestations), et le patient a ensuite droit à un remboursement du régime d'assurance-santé de l'Ontario. Le pourcentage de médecins qui se sont prévalus de cette disposition est tombé à environ un pour cent depuis l'entrée en vigueur de la *Loi sur l'accessibilité aux services de santé*, en 1986.

Les services médicaux assurés fournis dans les établissements de santé, les bureaux de médecins ou au domicile du patient sont détaillés dans le barème des prestations, selon le Règlement 552 de la *Loi sur l'assurance-santé* de l'Ontario. En termes généraux, ils comprennent :

- le diagnostic et le traitement des déficiences et conditions médicales;
- les examens et les tests médicaux;
- les procédures chirurgicales;
- les services de maternité;
- l'anesthésie;
- la radiologie et les services de laboratoire offerts dans des établissements approuvés;
- les vaccinations, les injections et les tests.

Des services sont ajoutés ou retirés (désassurés) du barème des prestations relatif aux services médicaux sur recommandation du Comité tarifaire central de *l'Association médicale de l'Ontario* en consultation avec des représentants du ministère de la Santé et des Soins de longue durée. Un groupe de travail sur le barème des prestations, lequel est composé de membres de *l'Association médicale de l'Ontario* et de représentants du Ministère, révisent régulièrement le barème des prestations. Des consultations publiques peuvent également être tenues. Des services sont ajoutés ou retirés du barème des prestations relatifs aux services médicaux par l'adoption d'un règlement.

2.3 Services de chirurgie dentaire assurés

En 2000-2001 le nombre de dentistes et de chirurgiens stomatologistes qui ont fourni des services assurés s'établissait à environ 350.

Les services hospitaliers de chirurgie dentaire assurés prescrits par l'article 16 et les annexes 13, 14 et 15 du Règlement 552 de la *Loi sur l'assurance-santé* de l'Ontario, comprennent les services suivants et doivent, par nécessité médicale, être effectuées à l'hôpital :

- le traitement des blessures traumatiques;
- les incisions chirurgicales;
- l'excision des tumeurs et des kystes;
- le traitement des fractures;
- les allogreffes;
- les implants;
- les reconstructions alloplastiques;
- toutes les autres pratiques dentaires spécifiées.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Seuls les services prescrits et fournis conformément à la *Loi sur l'assurance-santé* et ses règlements sont assurés. Tous les autres services ne sont pas assurés. L'article 24 du Règlement 552 renferme une liste non exhaustive des services qui sont désignés comme non assurés.

Les services hospitaliers non assurés comprennent :

- les frais supplémentaires reliés aux installations préférées, sauf si approuvé par un médecin, un chirurgien buccal et maxillo-facial ou une sage-femme;
- le téléphone et la télévision;
- les frais associés aux services d'une infirmière particulière;
- les chirurgies à caractère esthétique, dans la plupart des circonstances;
- la fourniture de médicaments à emporter à la maison, avec certaines exceptions;
- les visites à l'hôpital (à l'intérieur de la province) ayant pour seul but l'administration de médicaments, avec certaines exceptions.

Les services médicaux non assurés comprennent :

- les services non nécessaires sur le plan médical;
- les déplacements pour rendre visite à une personne assurée à l'extérieur de la zone de pratique;
- les frais d'appels interurbains;
- la préparation ou la fourniture d'un médicament, d'un antigène, d'un antisérum ou d'une autre substance, à moins que le médicament, l'antigène ou l'antisérum est utilisé pour facilité la procédure;
- les conseils donnés par téléphone à une personne assurée ou à une personne qui la représente;
- les entrevues ou les conférences au sujet d'un cas, selon certaines circonstances;
- la préparation et la transmission des dossiers à la demande de la personne assurée;
- les services dispensés totalement ou en partie pour la production ou l'achèvement d'un document ou la transmission d'information à un tiers dans des circonstances spécifiées;
- la production ou l'achèvement d'un document ou la transmission d'information à toute personne autre que la personne assurée, dans des circonstances spécifiées;
- la fourniture d'une ordonnance sans qu'un service concomitant ne soit rendu;
- la chirurgie à caractère esthétique;
- les pratiques d'acuponcture;
- les tests psychologiques;
- les programmes de dépistage en groupe;
- les programmes de recherche et d'enquêtes.

La liste ci-dessus n'est pas exhaustive et peut laisser place à des exceptions (voir l'article 24 du Règlement 552 de la *Loi sur l'assurance-santé*, le barème des prestations relatif aux services médicaux et l'article 11.2 de la *Loi sur l'assurance-santé*).

En outre, l'article 11.2(2) de la *Loi sur l'assurance-santé* stipule que les services auxquels une personne est admissible en vertu de la *Loi sur la sécurité professionnelle et l'assurance contre les accidents du travail*, de 1992, de la *Loi sur les foyers de soins spéciaux* ou de toute loi promulguée par le Parlement du Canada, à l'exception de la *Loi canadienne sur la santé*, ne sont pas des services assurés.

Les demandes de services formulées par des tiers ne sont généralement pas assurées par le régime d'assurance-santé de l'Ontario.

Selon la politique de l'assurance-santé de l'Ontario, les produits médicaux perfectionnés, tels que les moulages en fibre de verre, sont fournis sans frais au patient lorsqu'ils sont médicalement nécessaires.

Un médecin qui facture un patient ou accepte de ce dernier un montant supérieur au montant payable par le régime d'assurance-santé de l'Ontario commet une infraction à la loi provinciale. Toutefois, un médecin peut facturer un service non assuré par le régime d'assurance-santé de l'Ontario. Le Ministère ne réglemente pas les frais facturés pour des services non assurés; ces frais sont régis par l'Ordre des médecins et chirurgiens de l'Ontario. *L'Association médicale de l'Ontario* publie un barème des frais suggérés pour les services non assurés.

En 2000-2001, les recommandations du Groupe de travail sur le barème des prestations ont été mises en oeuvre dans trois secteurs. Les frais pour diverses interventions thérapeutiques ont été rayés du barème des prestations pour les services médicaux et des frais ont été ajoutés pour les traitements aux rayons ultraviolets en dermatologie. Les évaluations et les réévaluations des prothèses auditives ont été rayées du barème des médecins et, en même temps, la définition des personnes pouvant effectuer des tests auditifs de base et avancés a été clarifiée (aux fins de paiement). Un autre changement a établi le paiement maximal de 8 anesthésies par blocage nerveux par patient par jour pour toute combinaison d'anesthésie par blocage nerveux.

3.0 Universalité

3.1 Admissibilité au régime

Sauf quelques exceptions, tous les résidents de l'Ontario sont admissibles à la couverture; une période d'attente de trois mois peut toutefois être imposée. Les règlements d'application de la *Loi sur l'assurance-santé* de l'Ontario définissent les catégories de personnes qui sont résidentes de l'Ontario ainsi que celles qui sont soumises à une période d'attente de trois mois (voir l'article 11(1) de la *Loi sur l'assurance-santé* de l'Ontario et le Règlement 552 sous son régime).

Tous les résidents de l'Ontario qui veulent être couverts par le régime d'assurance-santé de l'Ontario doivent s'inscrire pour bénéficier de la couverture. Pour être considérée comme une résidente de l'Ontario aux fins de l'obtention d'une couverture du régime d'assurance-santé de l'Ontario, une personne doit :

- détenir le statut de citoyen ou d'immigrant prescrit (article 1.1(1) du Règlement 552 de la *Loi sur l'assurance-santé*);
- établir sa résidence permanente principale en Ontario, conformément au Règlement 552;
- en termes généraux, être présent physiquement en Ontario au moins 153 jours par période de douze mois.

Sauf quelques exceptions établies au paragraphe 3(4) du Règlement 552, la plupart des nouveaux résidents et des résidents de retour sont soumis à une période d'attente de trois mois. Le Ministère détermine si une personne est soumise ou non à une période d'attente de trois mois après que la personne au moment de faire la demande. Les anciens détenus fédéraux et les personnes nouvellement reconnues comme réfugiées au sens de la Convention sont parmi ceux qui sont exemptés de la période d'attente.

Les personnes non admissibles au régime d'assurance-santé de l'Ontario comprennent celles qui n'ont pas leur citoyenneté ou le statut d'immigrant tel que prescrit en vertu de l'article 1.1 (1) du Règlement 552, les détenus des pénitenciers fédéraux et les demandeurs du statut de réfugié. Les personnes qui n'étaient pas admissibles, mais dont le statut a changé (p. ex., changement du statut d'immigrant ou libération d'un pénitencier fédéral) peuvent, à la suite de la présentation d'une demande, être admissible à la couverture du régime d'assurance-santé de l'Ontario sous réserve des exigences du Règlement 552.

Aucune modification de la loi en 2000-2001 n'a eu de conséquence sur la clientèle admissible.

3.2 Exigences relatives à l'inscription au régime

Une carte santé est émise aux résidents qui adressent une demande au directeur général du régime d'assurance-santé de l'Ontario (selon les articles 2 et 3 du Règlement 552). La demande de couverture doit être formulée par les personnes admissibles qui établissent leur résidence permanente dans la province. Ces personnes doivent s'inscrire auprès du bureau local du régime d'assurance-santé de l'Ontario.

Les demandeurs doivent remplir et signer un formulaire d'inscription du régime d'assurance-santé de l'Ontario et fournir au Ministère des preuves de leur statut d'immigrant, de leur résidence et de leur identité. Les demandeurs doivent fournir chaque catégorie de documents originaux au moment de l'inscription. Une fois que l'admissibilité a été déterminée, les demandeurs âgés de plus de 15 ans et demi doivent généralement donner leur photographie et leur signature pour la carte santé.

Chaque carte santé avec photo est munie d'une date d'expiration et de renouvellement dans le coin inférieur droit. Le Ministère poste les avis de renouvellement à l'intention des personnes inscrites environ six semaines avant la date de renouvellement de la carte.

Le ministère de la Santé et des Soins de longue durée de l'Ontario est le seul payeur pour les services de santé assurés. Un résident de l'Ontario admissible ne peut s'inscrire ou obtenir des prestations auprès d'un autre régime d'assurance pour des services assurés par le régime d'assurance-santé de l'Ontario.

Environ 12 000 000 de résidents de l'Ontario étaient admissibles au régime d'assurance-santé de l'Ontario au 31 mars 2001.

3.3 Autres catégories de personnes

Le ministère de la Santé et des Soins de longue durée de l'Ontario offre une couverture à plusieurs catégories de personnes autres que des citoyens canadiens et des immigrants reçus. En général, ces personnes doivent fournir une preuve de citoyenneté ou de statut d'immigrant, une preuve de résidence et une preuve d'identité, de la même manière que les résidents permanents qui adressent une demande au régime d'assurance-santé de l'Ontario. On peut toutefois également exiger de ces demandeurs qu'ils fournissent de la documentation spécifique pour confirmer leur droit à la couverture du régime d'assurance-santé de l'Ontario ou, encore, ils peuvent être exemptés de certaines exigences. Les clients présentant une demande de couverture pour une de ces catégories doivent communiquer avec le bureau local du régime d'assurance-santé de l'Ontario pour obtenir de plus amples renseignements. On trouvera ci-après une vue d'ensemble des conditions d'admissibilité de ces demandeurs appartenant à d'autres catégories.

Les catégories de personnes suivantes sont admissibles si, d'une façon ou d'une autre, elles répondent à la définition de résident incluse au Règlement 552.

Demandeurs du statut d'immigrant reçu - Les demandeurs du statut d'immigrant reçu sont des personnes dont le dossier est en voie de traitement par Citoyenneté et Immigration Canada et qui, de façon générale, répondent aux exigences médicales de ce ministère. Un immigrant « reçu » est résident permanent du Canada. Environ 4 500 personnes étaient inscrites en tant que demandeurs du statut d'immigrant reçu au 31 mars 2001.

Réfugiés au sens de la Convention - La Commission de l'immigration et du statut de réfugié désigne une personne réfugiée au sens de la Convention lorsqu'on constate que cette personne craint la persécution dans son pays d'origine en raison de sa race, de sa religion, de sa nationalité, de son appartenance à un groupe social ou de son opinion politique. Environ 76 400 personnes étaient inscrites en tant que réfugiés au sens de la Convention au 31 mars 2001.

Détenteurs de permis ministériels - Les détenteurs de permis ministériels sont des personnes qui ne satisfont pas aux exigences d'immigration pour demeurer en permanence au Canada. Les détenteurs de permis ministériels correspondant aux types de cas 86, 87, 88, 89 ou 80 (adoption seulement) qui sont ordinairement résidents de l'Ontario

sont admissibles à la couverture du régime d'assurance-santé de l'Ontario pour la durée de validité de leur document d'immigration. Les détenteurs de permis ministériels correspondant au type de cas 90 ne sont pas admissibles à la couverture. Environ 800 personnes étaient inscrites en tant que détenteurs de permis ministériels au 31 mars 2001.

Travailleurs étrangers, ecclésiastiques étrangers et membres de leurs familles - Un ecclésiastique étranger admissible est une personne qui est parrainée par une organisation ou un culte religieux qui a conclu une entente pour servir à plein temps une congrégation religieuse en Ontario pendant au moins six mois consécutifs et qui réside habituellement en Ontario. Environ 1 100 personnes étaient inscrites en tant qu'ecclésiastiques étrangers admissibles au 31 mars 2001.

Un travailleur étranger est une personne qui a conclu un contrat ou une entente d'emploi avec un employeur canadien situé en Ontario et qui a reçu de Citoyenneté et Immigration Canada un permis de travail qui fait nommément mention de l'employeur canadien, indique la profession proposée de la personne, et dont la durée est d'au moins six mois. Environ 11 400 personnes étaient inscrites en tant que travailleurs étrangers admissibles au 31 mars 2001.

Les membres de famille admissibles sont le conjoint et les enfants à charge (âgés de moins de 19 ans) d'un ecclésiastique étranger ou d'un travailleur étranger admissible qui occupe un emploi pendant au moins trois années consécutives et qui réside habituellement en Ontario. Environ 7 700 personnes étaient inscrites en tant que membres de la famille accompagnant une personne en déplacement au 31 mars 2001.

Travailleurs agricoles migrants - Les travailleurs agricoles migrants sont des personnes qui détiennent un permis de travail en vertu du Programme des travailleurs saisonniers agricoles des Antilles, du Commonwealth et du Mexique administré par Citoyenneté et Immigration Canada. En raison de la nature particulière de leur emploi, les travailleurs agricoles migrants ne sont pas tenus de présenter les documents de résidence généralement exigés pour établir l'admissibilité à la couverture du régime d'assurance-santé de l'Ontario. Les membres de ce groupe sont également dispensés de la période d'attente de trois mois. Environ 2 900 personnes étaient inscrites en tant que travailleurs agricoles migrants au 31 mars 2001.

Aides familiaux résidants - Les aides familiaux résidants sont des personnes qui ont reçu une autorisation d'emploi en vertu du Programme concernant les aides familiaux résidents (PAFR) ou le Programme concernant les employés de maison étrangers (PEME) administrés par le ministère fédéral de la Citoyenneté et de l'Immigration. Un aide familial résident est une personne qui possède une autorisation d'emploi émise par le ministère de la Citoyenneté et de l'Immigration du Canada sur laquelle est inscrit PAFR ou PEME et qui est résident habituel de l'Ontario. L'autorisation d'emploi pour les travailleurs du PAFR ou du PEME n'a pas à inscrire les trois conditions d'emploi particulières requises pour tous les autres travailleurs étrangers, et la période d'attente de trois mois s'applique aux aides familiaux résidents.

3.4 Primes

Le paiement de primes a été aboli en 1990.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes qui déménagent en Ontario et qui étaient précédemment assurées dans une autre province ou un autre territoire canadien sont admissibles à la couverture du régime d'assurance-santé de l'Ontario dès le premier jour du troisième mois suivant l'établissement de leur résidence en Ontario. Les nouveaux résidents de l'Ontario ou les résidents de retour qui n'étaient pas précédemment assurés par le régime d'une autre province ou d'un autre territoire sont admissibles à la couverture exactement trois mois après l'établissement de leur résidence en Ontario.

Ces exigences sont énoncées dans l'article 3 du Règlement 552 de la *Loi sur l'assurance-santé*.

4.2 Couverture durant des absences temporaires (au Canada)

L'Ontario respecte les conditions de l'Accord sur l'admissibilité et la transférabilité de l'assurance-hospitalisation et l'assurance médicale conclu entre les provinces. Conformément à cet accord, les résidents assurés qui séjournent temporairement à l'extérieur de l'Ontario peuvent utiliser leur carte santé de l'Ontario pour obtenir des services de santé assurés. Les résidents assurés qui quittent temporairement l'Ontario pour voyager au Canada sans établir leur résidence dans une autre province ou un autre territoire continueront à être couverts pour une période pouvant aller jusqu'à douze mois.

Les services fournis à l'extérieur de la province sont couverts en vertu des articles 28(1), 30(1) et 32 du Règlement 552 de la *Loi sur l'assurance-santé*. Il est également possible aux résidents de l'Ontario de conserver une assurance-santé continuelle tandis qu'ils travaillent ou étudient temporairement dans une autre province ou un autre territoire canadien.

Une personne assurée par le régime d'assurance-santé de l'Ontario qui cherche ou accepte un emploi dans une autre province ou un autre territoire conserve sa couverture du régime d'assurance-santé de l'Ontario durant une période maximale de douze mois. Si la personne prévoit rester à l'extérieur de l'Ontario durant plus de douze mois, elle doit demander une couverture dans la province ou le territoire où elle cherche ou occupe un emploi.

Les étudiants assurés qui sont temporairement absents de l'Ontario, mais qui demeurent au Canada, sont admissibles à une couverture continuelle pendant la durée de leurs études à la condition qu'ils n'établissent pas leur résidence permanente ailleurs durant cette période. Afin de s'assurer qu'ils conservent leur admissibilité au régime d'assurance-santé de l'Ontario, les étudiants doivent fournir au Ministère une lettre de leur établissement d'enseignement confirmant qu'ils sont inscrits à temps plein. Les membres de la famille des étudiants qui poursuivent leur formation dans une autre province ou un autre territoire sont également admissibles à une couverture continuelle du régime d'assurance-santé de l'Ontario lorsqu'ils accompagnent un étudiant pour la durée de ses études.

L'Ontario participe aux ententes de réciprocité conclues entre toutes les provinces et les territoires pour l'assurance des services aux malades hospitalisés et aux malades externes. Pour les malades hospitalisés, le paiement est effectué selon le tarif prévu par le régime de la province ou du territoire où l'hospitalisation a lieu. Pour les malades externes, l'Ontario paie les frais standards autorisés par le Comité de coordination de la facturation réciproque.

En outre, l'article 28 du Règlement 552 de la *Loi sur l'assurance-santé* établit le paiement des services hospitaliers assurés qui sont fournis en dehors de l'Ontario mais au Canada et qui ne sont pas facturés en vertu d'ententes de réciprocité.

L'Ontario participe également aux ententes de facturation réciproque avec toutes les autres provinces et territoires, à l'exception du Québec (qui n'a pas signé d'entente de facturation réciproque avec une autre province ou un autre territoire), pour les services médicaux assurés.

4.3 Couverture durant des absences temporaires (à l'étranger)

La protection pendant des séjours temporaires à l'étranger est régie par les articles 28.1 à 31 (inclusivement) du Règlement 552 de la *Loi sur l'assurance-santé*.

Conformément aux articles 1.1(3), 1.1(4), 1.1(5) et 1.1(6) du Règlement 552 de la *Loi sur l'assurance-santé*, le ministère de la Santé et des Soins de longue durée de l'Ontario peut fournir aux résidents de l'Ontario assurés une admissibilité continuelle au régime d'assurance-santé de l'Ontario pour des absences excédant 212 jours par période de douze mois. Dans la plupart des cas, les demandeurs doivent fournir au Ministère un document expliquant les raisons de leur

absence de l'Ontario pour avoir droit à une absence approuvée. Les demandeurs doivent également avoir été présents au moins 153 jours durant chacune des deux périodes consécutives de douze mois précédant la date de départ prévue pour voir leur absence prolongée approuvée.

Les absences approuvées sont de durée variable selon la raison de l'absence.

Raison	Couverture du régime d'assurance-santé de l'Ontario
Études	Durée d'un programme d'études à temps plein (illimité).
Travail	Conditions de cinq ans.
Travail missionnaire	Durée des activités missionnaires (illimité).
Vacances/Autres	Jusqu'à deux ans au cours d'une vie.

Les membres de la famille peuvent également avoir droit à l'admissibilité continuelle au régime d'assurance-santé de l'Ontario lorsqu'ils accompagnent le demandeur principal au cours d'une absence approuvée. Ils doivent communiquer avec leur bureau local du régime d'assurance-santé de l'Ontario pour obtenir des détails.

Les services fournis à l'étranger sont couverts en vertu des articles 28.1 à 28.6 inclusivement et les articles 29 à 31 (inclusivement) du Règlement 552 de la *Loi sur l'assurance-santé*.

Depuis le 1er septembre 1995, les frais des services hospitaliers d'urgence fournis à l'étranger sont remboursés selon le tarif journalier suivant (fixé par l'Ontario) :

- 400 $ canadiens au maximum pour les services aux malades hospitalisés;
- 50 $ canadiens au maximum pour les services aux malades externes;
- 210 $ canadiens au maximum par traitement de dialyse.

Les services médicalement nécessaires rendus à l'étranger par des médecins et d'autres professionnels admissibles (chiropraticiens, dentistes, optométristes, podiatres et ostéopathes) ainsi que les tests de laboratoire nécessaires en situation d'urgence sont remboursés selon les tarifs énumérés au barème des prestations (Règlement 552) du ministère de la Santé et des Soins de longue durée de l'Ontario ou, encore, selon le montant facturé si ce dernier est inférieur. Les frais de services d'urgence médicalement nécessaires à l'étranger pour les malades hospitalisés et les malades externes sont remboursés seulement lorsqu'ils ont été rendus dans un hôpital ou un établissement de santé agréé.

En 2000-2001, le total des paiements pour les services hospitaliers et médicaux assurés fournis à l'étranger à des malades hospitalisés et des malades externes étaient 34,4 millions de dollars pour des services d'urgence. L'approbation préalable pour des services non urgents est traitée à la parti 4.4.

4.4 Nécessité d'une approbation préalable

Selon les dispositions de l'article 28.4 du Règlement 552 de la *Loi sur l'assurance-santé*, il est nécessaire d'obtenir une approbation préalable pour le paiement de services non urgents à l'étranger.

En vertu de l'article 28.4 du Règlement 552, le patient peut être autorisé à recevoir des services de santé à l'étranger, lesquels seront financés en totalité par le Ministère, lorsqu'un traitement médicalement accepté n'est pas disponible en Ontario ou que le patient fait face à un délai avant le début du traitement qui pourrait causer des dommages tissulaires irréversibles ou représenter une menace pour vie.

Il n'y a pas de processus d'approbation préalable officiel à l'égard des services fournis aux résidents de l'Ontario à l'extérieur de cette province, mais ailleurs au Canada. L'accord interprovincial comprend un barème pour les services dont les coûts sont élevés. Dans de rares circonstances, lorsque ce barème ne couvre pas les coûts des services dans une autre province, on peut demander à l'Ontario de garantir le paiement avant de fournir le service.

En 2000-2001, le montant total déboursé pour le paiement des traitements approuvés à l'extérieur du Canada s'élevait à 27,7 millions de dollars.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Tous les services hospitaliers, médicaux et dentaires assurés sont disponibles pour les résidents de l'Ontario selon des modalités et conditions uniformes.

Toutes les personnes assurées ont droit à tous les services hospitaliers et médicaux assurés, tels que définis dans la *Loi sur l'assurance-santé*. Les hôpitaux publics de l'Ontario n'ont pas le droit de refuser de fournir des services dans des situations où la vie de la personne est en danger sous prétexte que celle-ci n'est pas assurée. En vertu de la *Loi sur l'accessibilité aux services de santé*, il est interdit aux médecins inclus et exclus de facturer un montant supérieur à celui indiqué au barème de prestations de services médicaux. La surfacturation est également interdite aux médecins. En vertu de cette même loi, il est interdit aux hôpitaux de facturer les résidents assurés pour des services assurés.

Le ministère de la Santé et des Soins de longue durée a mis en oeuvre un système de validation des numéros de carte santé et de soins afin d'aider les dispensateurs de soins de santé et les patients à avoir accès aux services de santé et de favoriser le paiement des réclamations. Les dispensateurs de soins peuvent demander des privilèges de validation afin de vérifier l'admissibilité de leur patient et la situation du numéro de santé et du code (situation de la carte). Si des patients doivent avoir accès à des services de santé et qu'ils n'ont pas de carte santé en leur possession, le dispensateur de soins peut obtenir les renseignements nécessaires en présentant au Ministère un formulaire de divulgation de numéro d'assurance-santé signé par le patient. Un processus accéléré pour obtenir les numéros d'assurance-santé des patients qui sont dans l'incapacité de fournir un numéro et qui nécessitent un traitement d'urgence est offert dans les établissements de salle d'urgence par l'entremise d'un service de consultation des numéros de carte santé.

5.2 Accès aux services hospitaliers assurés

En 2000-2001, 155 hôpitaux publics dotés en personnel étaient en activité dans la province, incluant les unités pour malades chroniques, les unités de soins généraux et les unités de réadaptation spéciale. Le nombre de jours d'hospitalisation dans les hôpitaux publics s'établissait comme suit pour l'exercice 2000-2001 : 6 975 200 jours pour les soins actifs, 2 390 403 pour les soins aux malades chroniques et 646 839 pour les soins de réadaptation.

Voici quelques exemples de meilleur accès aux services :

- introduction du premier programme de thrombo-endariectomie pulmonaire;
- introduction d'une stratégie provinciale de lutte contre les accidents vasculaires cérébraux qui comprend des projets-pilotes en télémédecine à trois sites;
- augmentation des services cardiaques et rénaux par la mise en oeuvre de nouveaux programmes élargis;
- construction et expansion de centres anticancéreux;
- lits additionnels pour soins médicaux et critiques pour alléger les pressions exercées sur les services d'urgence;
- ajout de nouveaux lits de soins de longue durée;
- frais de scolarité payés pour les étudiants disposés à travailler en région rurale ou dans le nord;
- introduction de politiques pour garantir que les patients des salles d'urgence sont vus dans les 15 minutes suivants leur arrivée;
- amélioration des services de rééducation de la parole et du langage pour les enfants d'âge préscolaire;
- investissement dans le traitement des jeunes ayant des troubles de l'alimentation;
- meilleur accès aux programmes de dépistage du cancer du col utérin dans les régions éloignées.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

L'accès raisonnable aux services médicaux est assuré, en Ontario, par une distribution adéquate des médecins.

Un Programme des services aux régions insuffisamment desservies offre aux résidents des zones rurales et éloignées un accès amélioré aux services médicaux généraux. Quatre programmes renforcent l'accès aux services de santé pour les résidents du nord de l'Ontario. Le Plan de financement des groupes du Nord et les Contrats parrainés par la communauté offrent des mécanismes de financement de rechange pour verser à un groupe de médecins un montant global pour des services de soins de première ligne (pas de rémunération à l'acte). Le Programme de subventions d'encouragement pour les médecins offre une aide financière à des médecins généralistes et spécialistes oeuvrant dans une région insuffisamment desservie désignée. Enfin, le Programme de subventions aux résidents du Nord pour frais de transport à des fins médicales aide financièrement les patients qui doivent se déplacer pour recevoir des services hospitaliers et des services médicaux spécialisés.

À l'heure actuelle, 100 communautés de l'Ontario sont désignées comme insuffisamment desservies par des médecins de famille. Douze communautés sont désignées comme insuffisamment desservies par des spécialistes.

En date de mars 2001, on comptait environ 20 700 médecins actifs dont la plupart fournissaient des services médicaux assurés en Ontario. De ce nombre, 10 281 (49,7 pour cent) étaient des médecins de famille, et 10 392 (50,3 pour cent) étaient des spécialistes.

Quelques initiatives récentes annoncées au début de l'exercice 2000-2001 pour améliorer l'accès aux services médicaux comprennent la fourniture d'un enseignement gratuit et d'une prime d'emplacement aux étudiants et aux résidents en médecine qui acceptent de pratiquer dans une région insuffisamment desservie pendant au moins trois ans et l'ajout initial de 40 places d'étudiants en médecine pour l'automne 2000. Cette augmentation fait passer de 532 à 572 le nombre total de places d'entrée dans cinq écoles de médecine.

En vertu du programme de services médicaux d'extension (Programme de services itinérants offerts par des médecins), des cliniques de soins primaires peuvent être organisées régulièrement pour les collectivités éloignés qui ont un poste de soins infirmiers financé par l'entremise du Programme des services aux régions insuffisamment desservies et un soutien téléphonique peut être offert à l'infirmière ou à l'infirmière praticienne qui travaille au poste de soins infirmiers.

5.4 Rémunération des médecins

Les services assurés fournis par 20 500 médecins et 350 dentistes dans la province sont rétribués principalement selon la formule de la rémunération à l'acte conformément au barème des prestations relatif aux services médicaux en vertu de la *Loi sur l'assurance-santé*.

En avril 2000, le gouvernement de l'Ontario a négocié une entente quadriennale avec *l'Association médicale de l'Ontario* (OMA) pour déterminer les montants de financement pour les services médicaux en ce qui concerne les paiements des services rémunérés à l'acte. En 2000-2001, les médecins rémunérés à l'acte ont reçu 4,5 milliards de dollars pour des services médicaux, chirurgicaux et de diagnostic offerts aux résidents de l'Ontario.

Selon l'entente, un groupe de travail sur les barèmes des prestations, composé de représentants du ministère de la Santé et des Soins de longue durée et de *l'Association médicale de l'Ontario*, a reçu le mandat de déterminer les changements au barème actuel des prestations qui entraîneront des économies d'au moins 50 millions de dollars. Ces économies sont réalisées par le truchement d'initiatives de resserrement et de

modernisation. La première série de recommandations, qui devrait permettre d'économiser 20 millions de dollars par année, a été mise en oeuvre le 13 août 2001. Les autres mesures qui permettront d'économiser 30 millions de dollars devraient être mise en oeuvre au cours du prochain exercice.

Une commission sur les barèmes d'honoraires fondés sur les valeurs relatives en fonction des ressources (*Resource Based Relative Value Schedule*) (RBRVS) a été établie en 1997 par *l'Association médicale de l'Ontario* et le ministère de la Santé et des Soins de longue durée de l'Ontario, avec le mandat de fournir des recommandations concernant un nouveau barème d'honoraires fondé sur les valeurs relatives pour remplacer le barème actuel des prestations du régime d'assurance-santé de l'Ontario sans incidence sur les recettes. Un rapport provisoire assignant une nouvelle valeur à une liste de plus de 800 services a été présenté à *l'Association médicale de l'Ontario* et le ministère de la Santé et des Soins de longue durée de l'Ontario et les groupes intéressés pertinents le 7 septembre 2001 aux fins d'examen et de rétroaction. Les consultations avec *l'Association médicale de l'Ontario* se poursuivent.

Des représentants du gouvernement et la *Ontario Dental Association* négocient des accords sur des ajustements du barème des prestations du régime qui couvre les services dentaires assurés fournis à l'hôpital. En 1999-2000, les dépenses pour les soins dentaires s'établissaient à 8,1 millions de dollars. Le dernier accord de financement qui devait expirer le 31 mars 2000 est maintenant prolongé au 31 mars 2001. Des discussions pour un nouvel accord pluriannuel ont débuté à l'automne 2000.

5.5 Paiements aux hôpitaux

Les hôpitaux soumettent un plan de fonctionnement annuel, lequel résulte d'une large consultation au sein de l'établissement (tous les échelons de personnel, les syndicats, les médecins, le conseil, etc.), de la communauté et de la région. Le plan de fonctionnement est d'abord et avant tout un document de planification, mais il comporte une composante budgétaire importante qui est à la fois financière et statistique. Le conseil régional de santé (CRS) et le personnel du ministère de la Santé et des Soins de longue durée examinent ensuite le plan de fonctionnement. L'examen du Ministère est effectué par le personnel régional, le personnel des programmes spécialisés et la haute direction. Cet examen suit des lignes directrices standard et peut faire intervenir des discussions et une clarification approfondies avec l'établissement.

Les paiements versés aux hôpitaux par le régime d'assurance-santé pour les services assurés sont régis par la *Loi sur l'assurance-santé* et sont calculés selon un budget annuel. Le système budgétaire de l'Ontario est un système de remboursement prospectif qui reflète les effets de l'augmentation de la charge de travail, des coûts associés aux programmes prioritaires de la province et des augmentations des coûts associées à la croissance supérieure à la moyenne du volume de services dans des lieux géographiques spécifiques. Les paiements sont versés aux hôpitaux deux fois par mois.

Les paiements pour des services rendus dans des établissements de santé autonomes sont régis par la *Loi sur les établissements de santé autonomes*.

Les règlements et les tarifs relatifs à la quote-part des malades chroniques sont révisés annuellement selon les changements apportés au Régime de pensions du Canada (RPC).

Les programmes prioritaires sont des programmes divers qui nécessitent des ressources humaines et des infrastructures hautement spécialisées. Ces programmes sont souvent très coûteux et à croissance rapide. Ils peuvent être associés à des traitements nouvellement élaborés qui incluent des thérapies et technologies de pointe. En général, ces programmes sont gérés à l'échelle de la province et sont conçus pour assurer un accès équitable. Le Ministère en détermine le financement selon les besoins de la population et les preuves de résultats cliniques.

Les programmes prioritaire comprennent :

- les traumatismes crâniens;
- le cancer, les services cardiaques;
- les implants cochléaires;

- le programme de traitement du bec-de-lièvre et de la fissure du palais;
- les maladies rénales en phase terminale;
- les services génétiques (laboratoires de cytogénétique, dépistage sérologique chez la mère, laboratoires d'analyse moléculaire et de l'ADN);
- les cliniques pour le VIH/sida;
- l'imagerie (IRM);
- les services maternels aux nouveaux-nés;
- les implants orthopédiques de la hanche et du genou;
- le programme de gériatrie régionale;
- les accidents vasculaires cérébraux;
- les centres de traitement des agressions sexuelles;
- les transplantations (organes solides, moelle osseuse); et
- les centres de traumatologie.

Le Ministère mesure les coûts-efficacité relatifs et récompense les hôpitaux par l'intermédiaire du modèle d'allocation intégrée selon la population (Integrated Population-Based Allocation - IPBA - model). Des paiements sont versés aux hôpitaux qui dépensent moins que prévu en prenant en considération les caractéristiques particulières de l'hôpital.

En outre, des méthodes spécialisées sont utilisées pour le financement enrichi d'initiatives liées à des politiques et programmes spécifiques (c.-à-d., perfectionnement des infirmières, séjour garanti de 60 heures après l'accouchement).

Le financement des soins aux patients dans les hôpitaux a augmenté de plus de 1,3 milliard de dollars en 2000-2001, ce qui porte le financement total des hôpitaux à plus de 8,7 milliards de dollars en 2000-2001 comparativement à 7,4 milliards de dollars en 1999-2000.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement de l'Ontario a reconnu publiquement la contribution fédéral au titre du Transfert canadien en matière de santé et de programmes sociaux dans ses publications de 2000-2001.

7.0 Services complémentaires de santé

Les services de soins complémentaires de santé sont assurés par les maisons de soins infirmiers, les résidences pour personnes âgées (établissements de soins de longue durée) et les dispensateurs de services de soins à domicile. Ils sont financés par le ministère de la Santé et des Soins de longue durée. Le Ministère participe au processus de vérification de la conformité pour les établissements de soins de longue durée en offrant des services de consultation diététiques, environnementaux et médicaux et en examinant les normes de santé, de sécurité, de construction et de diététique. Il surveille comment les établissements observent ces normes et peut les aider à l'élaboration de plans d'action correctifs.

Les services de soins à domicile (services professionnels, soutien personnel et aide familiale) sont financés par le Ministère et fournis par les Centres d'accès aux soins communautaire aux personnes de tous les âges. Le Ministère finance des services auxiliaires pour les adultes handicapés physiques et des services de soutien au logement pour les personnes âgées, les adultes handicapés physiques, les adultes souffrant de lésions cérébrales acquises et les personnes vivant avec le VIH/sida. Le Ministère finance également une variété de services de soutien communautaire tels que les programmes de jour pour adultes, les services de repas et les services de transport.

Outre les prestations d'hospitalisation, l'Ontario fournit une grande variété de services de santé notamment des services de soins de longue durée; des services de santé mentale, incluant le fonctionnement d'hôpitaux psychiatriques provinciaux, ainsi que les services en santé mentale et les services de soutien offerts dans la communauté; la composante résidentielle du Programme des foyers de soins spéciaux; des services d'ambulance par voie aérienne avec une quote-part pour le patient; des traitements dentaires pour les patients souffrant de bec-de-lièvre et de fissure du palais inscrits dans une clinique désignée; du financement pour un programme de dépistage du cancer du sein.

Documents supplémentaires présentés à Santé Canada

Rapports annuels

- Plan d'activités du ministère de la Santé et des Soins de longue durée : www.gov.on.ca/health/english/pub/ministry/bplan01/bplan01.html

Rapports de vérification

- Régime d'assurance-santé de l'Ontario, 1998 (rapport du vérificateur provincial) : www.gov.on.ca/opa/french/f98/306.htm
- Régime d'assurance-santé de l'Ontario - suivi de 2000 (rapport du vérificateur provincial) : www.gov.on.ca/opa/french/r2000t_fr.htm

Rapports financiers

- Budget 2000-2001 : www.gov.on.ca/FIN/french/budfre.htm#Budget
- Comptes publics 2000-2001 : www.gov.on.ca/FIN/french/budfre.htm#public

Lois

- *Loi sur l'assurance-santé*
- *Règlements de la Loi sur l'assurance-santé*
- *Loi sur les hôpitaux publics*
- *Loi sur les établissements de santé autonomes*
- *Loi sur l'accessibilité aux services de santé*

Manitoba

Introduction

Les soins de santé constituent une priorité absolue pour les Manitobains

Le Manitoba a été reconnu à l'échelle nationale, par l'Institut canadien d'information sur la santé, comme ayant le meilleur plan au pays pour mettre fin à la médecine de corridor. Grâce à l'élargissement des soins à domicile, à une meilleure coordination des ressources hospitalières et au plus imposant programme de vaccination contre la grippe de l'histoire de la province, le Manitoba a réussi à réduire de 80 pour cent le nombre de patients traités dans les corridors au cours de l'année 2000.

Le plan en cinq points du Manitoba visant à mettre fin à la médecine de corridor dans les hôpitaux a été introduit en 2000 et comprenait les mesures suivantes :

- l'ouverture de nouveaux lits;
- l'amélioration des procédures d'admission et de congé;
- l'élargissement des services communautaires;
- le renforcement des programmes de prévention comme la vaccination contre la grippe;
- l'augmentation du nombre de programmes de soins à domicile et de programmes de soins de jour pour adultes.

Le Manitoba doit relever le défi national et mondial de régler la pénurie de professionnels de la santé. L'incapacité antérieure d'assurer la formation requise s'est soldée par des pénuries de personnel et des listes d'attente plus longues pour les examens et le traitement. Des progrès sont en train d'être accomplis afin de régler cette pénurie par le truchement d'une gamme de stratégies de formation, de recrutement et de maintien en poste.

Tous les jours, des infirmières de l'ensemble du Manitoba démontrent leur engagement vis-à-vis du bien-être des Manitobains en leur prodiguant des soins professionnels et compétents. À son tour, le gouvernement du Manitoba a pris un engagement envers les infirmières dans deux secteurs clés, notamment :

- le recrutement d'un nombre suffisant d'infirmières dans divers secteurs des soins infirmiers;
- le maintien en poste d'infirmières dans des milieux de travail qui respectent et maximisent les compétences professionnelles et l'expérience des infirmières pour le bien-être des patients et des clients.

Au printemps de l'année 2000, le gouvernement du Manitoba a annoncé une stratégie sur les soins infirmiers en cinq points afin de traiter des préoccupations soulevées par les infirmières et d'autres intervenants du système de soins de santé. La stratégie vise notamment :

1. à améliorer les conditions de travail;
2. à accroître les effectifs infirmiers;
3. à améliorer l'accès à l'éducation permanente;
4. à améliorer l'utilisation de toutes les catégories d'infirmières;
5. à accroître la participation des infirmières au processus décisionnel.

Le rôle de Santé Manitoba

Santé Manitoba est un ministère hiérarchique dans la structure organisationnelle et il est exploité en vertu des dispositions des lois et des responsabilités confiées au ministre de la Santé. Les mandats officiels contenus dans la législation, assortis aux mandats résultant des réponses aux questions de santé et de soins de santé nouvelles, forment le cadre pour la planification et la prestation des services.

Santé Manitoba a pour mandat d'assurer le leadership et le soutien nécessaires pour protéger, conserver et promouvoir la santé de tous les Manitobains. Cette mission est réalisée par le truchement d'une structure d'enveloppes globales comprenant l'obligation de rendre compte des programmes, des politiques et des finances; de l'établissement de judicieuses politiques gouvernementales, et de la prestation de services de santé et de soins de santé pertinents, efficaces et efficients. Les services sont assurés par l'entremise des systèmes de prestation régionaux, des hôpitaux et d'autres établissements de soins de santé. Le ministère verse également, au nom des Manitobains, des paiements au titre des services de santé assurés reliés aux coûts des soins médicaux, des soins hospitaliers, des soins personnels, de l'assurance-médicaments et d'autres services de santé.

La vision du Manitoba est de jouer un rôle de chef de file dans le système de soins de santé de qualité, lequel repose sur la créativité, la compassion, la confiance et le respect; d'habiliter les Manitobains grâce aux connaissances, aux choix et à l'accès aux meilleures ressources sanitaires possibles; et de former des partenariats et des alliances pour la santé et la promotion de collectivités offrant un soutien.

Santé Manitoba a également le rôle de favoriser l'innovation dans le système de soins de santé. Pour ce faire, il prévoit l'établissement de mécanismes pour évaluer et surveiller la qualité, l'utilisation et la rentabilité des soins; il favorise les comportements et les milieux qui permettent de promouvoir la santé; et veille à la promotion de la réceptivité et de la souplesse des systèmes de prestation, ainsi que la prestation de services de rechange moins coûteux.

1.0 Gestion publique

1.1 Régime d'assurance santé et autorité publique

Le régime d'assurance-maladie du Manitoba est géré par le ministère de la Santé en vertu de la *Loi sur l'assurance-maladie*, R.S.M. 1987, ch. H35. En 1992, des modifications importantes ont été apportées à cette Loi : la Commission des services de santé du Manitoba a été dissoute et tous ses biens et responsabilités ont été transférés au ministère de la Santé. Cette dissolution a pris effet le 31 mars 1993.

Le régime d'assurance-maladie du Manitoba est géré conformément à la *Loi sur l'assurance-maladie* pour tous les aspects touchant l'assurance relative aux coûts des services hospitaliers, personnels et médicaux et des autres services de santé auxquels il est fait allusion dans les lois des autorités législatives ou règlements pris en application de celles-ci.

La Loi a été modifiée le 1er janvier 1999 afin de prévoir la couverture des services pour malades externes assurés relativement aux services médicaux assurés offerts dans les installations chirurgicales.

Le ministre de la Santé est chargé de la gestion et du fonctionnement du régime. En vertu du paragraphe 3(2), le ministre peut :

a) fournir aux résidents de la province une assurance relative aux coûts des services hospitaliers, des soins médicaux, des soins personnels et d'autres services de santé;

b) planifier, organiser et mettre sur pied à travers la province un réseau équilibré et intégré d'hôpitaux, de foyers de soins personnels ainsi que d'établissements et de services liés au domaine de la santé santé qui répondent aux besoins des résidents de la province;

c) faire en sorte que des normes satisfaisantes soient maintenues dans les hôpitaux, dans les foyers de soins personnels ainsi que dans les établissements liés au domaine de la santé, y compris les normes relatives à la surveillance, à la délivrance de licences, à l'équipement et à l'inspection ou prendre les dispositions qu'il juge nécessaires afin d'assurer le maintien de normes satisfaisantes;

d) sauf dans le cas des soins individuels aux malades, fournir un service de consultation aux hôpitaux et aux foyers de soins personnels de la province ou prendre les dispositions qu'il juge nécessaires afin d'assurer qu'un tel service soit fourni;

e) exiger que les dossiers des hôpitaux, des foyers de soins personnels et des établissements liés au domaine de la santé soient vérifiés tous les ans et que les rapports que requiert le gouvernement du Canada à l'égard des hôpitaux soient présentés;

f) dans les cas où les résidents n'ont pas accès à des soins médicaux et à d'autres services de santé, prendre les mesures qu'il juge nécessaires pour planifier, organiser et mettre sur pied de tels services afin de répondre aux besoins des résidents.

Le ministre peut également conclure, avec des personnes ou des groupes de personnes les contrats et ententes qu'il juge nécessaires pour l'application de la présente loi. Il peut également octroyer des subventions à une personne ou à un groupe de personnes pour l'application de la présente loi, sous réserve des conditions qu'il juge opportunes. Le ministre peut également, par écrit, déléguer à quiconque les pouvoirs ou fonctions que lui confèrent la présente loi ou les règlements.

1.2 Liens hiérarchiques

Aux termes de l'article 6 de la Loi, le ministre doit préparer les états financiers vérifiés du régime et y faire état séparément des dépenses se rapportant aux services hospitaliers, et soins médicaux ainsi qu'aux autres services de santé. Le ministre est également tenu de faire préparer un rapport annuel qui doit comprendre les états financiers vérifiés, et il doit déposer une copie du rapport annuel à l'Assemblée législative dans les 15 premiers jours de séance de celle-ci, suivant sa réception. Si l'Assemblée ne siège pas, le rapport doit être déposé dans les 15 jours suivant le début de la session suivante.

1.3 Vérification des comptes

L'article 7 de la Loi sur l'assurance-maladie exige que le vérificateur provincial (ou un autre vérificateur qu'il nomme) fasse une vérification annuelle des comptes du régime et prépare un rapport au ministre. Le plus récent rapport du genre, qui vise l'exercice 1999-2000, fait partie du Rapport annuel 1999-2000 de Santé Manitoba.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les articles 46 et 47 de la *Loi sur l'assurance-maladie* du Manitoba de même que le Règlement sur l'assurance-hospitalisation et l'administration des hôpitaux (M.R. 48/93) prévoient la prestation de services hospitaliers assurés.

Au 31 mars 2001, 98 établissements fournissaient des services hospitaliers assurés aux malades hospitalisés et aux malades externes au Manitoba. En vertu de la *Loi sur l'assurance-maladie*, les hôpitaux sont désignés par règlement.

Les services spécifiés par règlement comme étant des services hospitaliers assurés fournis aux malades hospitalisés et aux malades externes comprennent :

- l'hébergement et les repas en chambre ordinaire;
- les soins infirmiers nécessaires;
- les services de laboratoires, de radiologie et autres services de diagnostic;
- les médicaments, les produits biologiques et les préparations connexes;

- les fournitures médicales et chirurgicales ordinaires;
- l'utilisation des salles d'opération, des salles d'observations et des installations d'anesthésie;
- l'utilisation des installations de radiothérapie, de physiothérapie, d'ergothérapie et d'ortophonie, là ou elles existent.

La population du Manitoba a des attentes très élevées quant à la qualité des soins de santé et elle insiste pour que les connaissances médicales les plus poussées et les services les plus au point soient utilisés pour son état de santé personnel. Santé Manitoba se tient au courant des découvertes dans les domaines des sciences de la santé.

2.2 Services médicaux assurés

La loi d'autorisation qui prévoit la prestation de services médicaux assurés est le Règlement sur l'assurance relative aux soins médicaux (Règlement 49/93) pris en application de la *Loi sur l'assurance-maladie*.

Les médecins qui offrent des services assurés au Manitoba doivent être légalement autorisés à exercer la médecine au Manitoba autorisés et agréés en vertu de la *Loi médicale*. Au 31 mars 2001, 2 045 médecins étaient inscrits au registre de Santé Manitoba.

En vertu de la *Loi sur l'assurance-maladie* et des règlements pris en application de celle-ci, un médecin peut, sur présentation d'un avis au ministre, choisir de percevoir des honoraires auprès d'une autre personne que le ministre pour les services médicaux dispensés à des personnes assurées. La décision de se retirer du régime d'assurance-santé entre en vigueur le premier jour du mois suivant une période de 90 jours commençant à la date où le ministre reçoit l'avis.

Avant de dispenser un service médical à une personne assurée, le médecin doit donner au patient un préavis raisonnable selon lequel il propose de percevoir des honoraires pour le service médical rendu; auprès de celui-ci ou de toute autre personne, à l'exception du ministre. Il incombe au médecin de soumettre, au nom du patient, une demande au ministre; le médecin ne peut percevoir des honoraires en sus des prestations à payer pour ce service, aux termes de la Loi et des règlements. À l'heure actuelle, aucun médecin du Manitoba n'a décidé de se retirer du régime médical.

Dans le Règlement sur les frais assurés engagés pour des services médicaux (M.R. 95/96), on trouve la liste des services médicaux assurés par Santé Manitoba. Cette garantie s'applique à tous les services de soins personnels fournis par un médecin à une personne assurée lorsqu'ils sont nécessaires du point de vue médical et non exclus en vertu du Règlement sur les services exclus (Règlement 46/93) pris en application de la *Loi sur l'assurance-maladie*. Au cours de l'exercice 2000-2001, un certain nombre de nouveaux services assurés ont été ajoutés au barème d'honoraires révisé.

Afin qu'un service de médecin puisse être ajouté à la liste de services assurés par Santé Manitoba, le médecin doit présenter une proposition à la section de la l'Association médicale du Manitoba dont il relève. Les propositions sont acheminées au Manitoba College of Physicians and Surgeons qui vérifie que le service est scientifiquement valide et non en voie d'élaboration ou à l'étape expérimentale. L'Association médicale négocie alors le service en question, y compris les honoraires, avec Santé Manitoba. Le processus peut également être amorcé par Santé Manitoba.

2.3 Services de chirurgie dentaire assurés

Dans le Règlement sur l'assurance-hospitalisation et l'administration des hôpitaux (Règlement 48/93) pris en application de la *Loi sur l'assurance-maladie*, on trouve la liste des services de chirurgie dentaire qui sont assurés. Ces services chirurgicaux sont assurés lorsqu'ils sont rendus par un chirurgien diplômé en chirurgie buccale et maxillo-faciale ou un dentiste autorisé à exercer sa profession dans un hôpital, et qu'il est nécessaire d'hospitaliser le patient pour accomplir l'acte correctement. Ce règlement prévoit également des prestations relativement au coût des services d'orthodontie assurés dans les cas de bec-de-lièvre et de

fissure du palais chez les personnes inscrites au programme avant leur dix-huitième anniversaire, et ce, lorsque les services sont assurés par un orthodontiste autorisé. Au 31 mars 2001, 555 dentistes étaient inscrits auprès de Santé Manitoba, dont 105 avaient reçu des paiements pour des services assurés.

Les dispensateurs de services dentaires peuvent, à l'instar des médecins, décider de percevoir leurs honoraires directement auprès du patient. Et ne doivent pas percevoir auprès d'une personne assurée des frais pour ces services médicaux ou pour d'autres services de santé qui dépassent les prestations à payer aux termes de la Loi ou des règlements. Au 31 mars 2001, aucun dispensateur de services dentaires n'avait opté pour le retrait du régime d'assurance-maladie.

Afin qu'un service dentaire soit ajouté à la liste des services assurés, un dentiste doit soumettre une proposition à la Manitoba Dental Association (MDA). La MDA négocie les honoraires avec Santé Manitoba.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Les services médicaux non assurés comprennent :

- les examens et les rapports établis à des fins d'emploi, d'assurance, de fréquentation d'une université ou d'un camp, ou encore les services rendus à la demande de tiers;
- les services d'immunisation et autres services offerts à des groupes, sauf s'ils sont autorisés par le ministère de Santé Manitoba;
- les soins que des médecins, dentistes, chiropraticiens ou optométristes se dispensent à eux-mêmes ou dispensent aux personnes à leur charge;
- la préparation de dossiers, de rapports, de certificats, de communications et de témoignages devant un tribunal;
- le kilométrage ou le temps de déplacement; les services de psychologues, podologues et autres praticiens dont les services ne sont pas mentionnés dans la législation;
- la fécondation in vitro;
- l'enlèvement de tatouages;
- l'ajustement de lentilles cornéennes;
- le rétablissement de la fécondité; et
- la psychanalyse.

La Loi sur l'assurance-maladie stipule que les soins à l'hôpital comprennent les fournitures médicales et chirurgicales courantes, permettant ainsi d'assurer un accès raisonnable à tous les résidents. Les Offices régionaux de la santé et Santé Manitoba vérifient la conformité.

Afin de supprimer des services actuellement assurés par Santé Manitoba, le Ministère doit préparer une soumission et la soumettre à l'approbation du Cabinet. Selon le service en cause, il faudrait déterminer, au cas par cas, s'il est nécessaire de recourir à une consultation publique.

En 2000-2001, aucun service n'a été supprimé de la liste des services assurés par Santé Manitoba.

3.0 Universalité

3.1 Admissibilité au régime

La Loi sur l'assurance-maladie est la loi qui définit l'admissibilité des résidents du Manitoba au régime d'assurance-santé de la province. Le paragraphe 1 de l'article 2(1) de la Loi stipule qu'un « résident » est une personne qui est légalement autorisée à habiter au Canada, qui réside au Manitoba et y est personnellement présente au moins six mois par année civile. Cette définition vise notamment toute autre personne qui, en vertu des règlements, est considérée comme un résident ; mais elle exclut, sauf indication contraire du ministre, les personnes titulaires d'un permis ministériel délivré en vertu de la *Loi sur l'immigration* (Canada), ainsi que les visiteurs, les personnes de passage et les touristes.

Le Règlement sur la résidence et l'inscription a pour effet d'élargir l'acception du terme résidence. On trouve ces définitions élargies aux articles 7(1) et 8(1). L'article 7 a

pour effet de permettre aux missionnaires et aux personnes qui s'absentent du pays pour une raison d'emploi ainsi que les personnes qui prennent un congé sabbatique et celles qui s'absentent du Manitoba pour une période pouvant aller jusqu'à 24 mois de demeurer résidents du Manitoba. Les étudiants qui fréquentent à temps plein un établissement d'enseignement agréé sont réputés être résidents du Manitoba. L'article 8(1) a pour effet d'élargir l'acception du terme résidence aux personnes légalement autorisées à travailler au Manitoba et qui ont le droit de travailler pendant une période de 12 mois ou plus.

L'article 6 du Règlement sur la résidence et l'inscription définit la période d'attente de la façon suivante :

> « Un résident qui, immédiatement avant son arrivée au Manitoba, était résident d'une autre province ou d'un territoire canadien n'est pas assuré avant le premier jour du troisième mois qui suit le mois de son arrivée. »

Il n'existe actuellement aucune autre période d'attente au Manitoba.

Le régime d'assurance-santé du Manitoba exclut les résidents qui sont couverts par les lois fédérales suivantes : *Loi sur l'aéronautique*; *Loi sur les avantages liés à la guerre pour les anciens combattants de la marine marchande et les civils*; *Loi sur l'indemnisation des agents de l'État*; *Loi sur l'indemnisation des marins marchands*; *Loi sur la défense nationale*; *Loi sur les pensions*; *Loi sur la Gendarmerie royale du Canada*; *Loi sur la réadaptation des anciens combattants* ou par toute autre loi relevant d'un autre secteur de compétence. Au paragraphe 2(2) du Règlement sur les services exclus on fait état des résidents inadmissibles susmentionnés. Les exclusions visent les résidents qui sont membres des Forces armées canadiennes, de la Gendarmerie royale du Canada et les personnes purgeant une peine d'emprisonnement dans un pénitencier fédéral. Les résidents deviennent admissibles à la couverture de Santé Manitoba une fois qu'ils cessent d'être membres des Forces canadiennes; ou membres de la GRC ou détenus dans un pénitencier sans avoir de personne à charge résidant dans la province. Au paragraphe 2(3) du Règlement sur la résidence et l'inscription lorsque la personne change de statut, elle dispose d'un mois pour s'inscrire auprès de Santé Manitoba.

3.2 Exigences relatives à l'inscription au régime

Aux fins de la délivrance des cartes d'assurance-santé, les personnes doivent aviser Santé Manitoba qu'elles sont légalement autorisées à être au Canada, qu'elles ont l'intention d'habiter pendant six mois au Manitoba et fournir une adresse de résidence principale dans la province. Au reçu de ces renseignements, Santé Manitoba émet un certificat d'inscription à cette personne ainsi qu'à toutes les personnes admissibles à sa charge.

Au Manitoba, deux numéros sont liés à la santé : le numéro d'inscription est un numéro à six chiffres attribué à une personne âgée de 18 ans ou plus qui n'est pas considérée comme une personne à charge. On utilise ce chiffre pour cette personne ainsi que pour toutes les personnes désignées qui sont à sa charge. Santé Manitoba utilise ce chiffre pour régler les demandes de remboursement des services hospitaliers et médicaux. Un numéro d'identification personnelle de santé (NIPS) de neuf chiffres est requis pour le programme des médicaments provincial.

En 2000-2001, le nombre de résidents inscrits auprès du régime d'assurance-santé était de 1 149 904.

Le régime de santé du Manitoba ne prévoit aucune possibilité de retrait pour les résidents.

3.3 Autres catégories de personnes assurées

Aux termes du paragraphe 8(1) du Règlement sur la résidence et l'inscription, les travailleurs temporaires doivent être titulaires d'un permis de travail délivré par Citoyenneté et Immigration Canada (CIC) pour au moins 12 mois

consécutifs, être physiquement présents au Manitoba et légalement autorisés à demeurer au Canada afin d'avoir droit à l'assurance couverture de Santé Manitoba.

En 2000-2001, 899 personnes titulaires d'un permis de travail étaient assurées par le régime d'assurance-santé du Manitoba.

Selon la définition du terme « résident » donnée dans la *Loi sur l'assurance-maladie*, le ministre de la Santé, ou son mandataire désigné, peut fournir l'assurance aux titulaires d'un permis ministériel délivré en vertu de la *Loi sur l'immigration* (Canada). En 2000-2001, cinq personnes ont eu droit à cette couverture parce qu'elles étaient titulaires d'un tel permis ministériel.

4.0 Transférabilité

4.1 Délai minimal de résidence

L'article 6 du Règlement sur la résidence et l'inscription fixe la période d'attente pour les autres personnes assurées qui déménagent d'une province ou d'un territoire pour s'installer au Manitoba. Un résident qui, immédiatement avant son arrivée au Manitoba, était résident d'une autre province ou d'un territoire canadien est assuré le premier jour du troisième mois qui suit son arrivée.

4.2 Couverture durant des absences temporaires (au Canada)

Le paragraphe 7(1) du Règlement sur la résidence et l'inscription définit les règles de transférabilité de l'assurance-santé pendant des absences temporaires du Canada.

Les étudiants sont considérés comme des résidents et ils continuent d'être assurés par l'assurance-santé pendant toute la période où ils sont inscrits à temps plein dans tout établissement d'enseignement agréé. Une exigence supplémentaire veut qu'ils aient l'intention de retourner au Manitoba et de s'y installer après avoir terminé leurs études.

Les résidents qui sont en congé sabbatique ou en congé d'études sont assurés par Santé Manitoba pendant une période pouvant aller jusqu'à 24 mois consécutifs. Ces personnes doivent retourner au Manitoba et y résider une fois que leur congé d'études est terminé.

Le Manitoba a signé des ententes formelles avec toutes les provinces et chacun des territoires canadiens aux fins de la facturation réciproque des services hospitaliers assurés. Le Manitoba a signé un accord bilatéral avec la Saskatchewan pour les résidents de la Saskatchewan qui reçoivent des soins dans des localités frontalières du Manitoba.

Les coûts d'hospitalisation sont fixés selon les taux normaux approuvés par la province ou le territoire d'accueil. Les paiements versés pour les actes médicaux à coût élevé visant des patients hospitalisés et les services offerts à des patients externes sont établis d'après des taux nationaux établis par les régimes de santé provinciaux/territoriaux. Ils comprennent tous les services nécessaires du point de vue médical de même que les coûts relatifs aux soins d'urgence.

Les services médicaux reçus dans toutes les provinces – à l'exception du Québec – et tous les territoires sont payés en vertu d'ententes de facturation réciproque et ce sont les taux de la province ou du territoire d'accueil qui déterminent le coût de ces services. Les demandes de remboursement pour services médicaux reçus au Québec sont soumises par le patient ou le médecin à Santé Manitoba afin d'être réglées selon les taux de la province d'accueil.

En 2000-2001, Santé Manitoba a versé des paiements totalisant environ 16 241 775 $ pour des services hospitaliers et 6 201 408 $ pour des services médicaux fournis au Canada.

4.3 Couverture durant des absences temporaires (à l'étranger)

Paragraphe 1 de l'article 7(1) du Règlement sur la résidence et l'inscription définit les règles de transférabilité de l'assurance-santé pendant les absences temporaires du Canada.

Les résidents qui occupent un emploi sous contrat à temps plein, à l'extérieur du Canada, auront droit à la couverture de Santé Manitoba pendant une période pouvant aller jusqu'à 24 mois consécutifs. Ils doivent retourner au Canada et y résider après avoir terminé leurs contrats. Les membres du clergé qui vont en mission, pour le compte d'une organisation religieuse ayant le statut d'organisme de bienfaisance en vertu de la *Loi de l'impôt sur le revenu* (Canada); seront assurés par Santé Manitoba pour une période pouvant aller jusqu'à 24 mois consécutifs. Les étudiants sont considérés comme des résidents et continueront d'avoir droit à l'assurance de santé pendant la durée de leur inscription à temps plein dans un établissement d'enseignement agréé. Une exigence supplémentaire veut qu'ils aient l'intention de revenir au Manitoba et d'y résider à la fin de leur programme d'études. Les résidents en congé sabbatique ou en congé d'études pour suivre un cours de formation avancée ou complémentaire seront assurés par Santé Manitoba pour une période allant jusqu'à 24 mois consécutifs. Ces personnes doivent également revenir au Manitoba et y résider à la fin de leur programme d'études.

Pour chacune de ces catégories, l'assurance est assujettie aux montants indiqués dans le Règlement sur l'assurance-hospitalisation et l'administration des hôpitaux. Les services hospitaliers reçus à l'extérieur du Canada en raison d'une urgence ou d'une maladie apparue subitement et pendant une absence temporaire du Canada, sont défrayés comme suit :

Les services aux patients hospitalisés sont payés selon un taux quotidien établi d'après le nombre de lits que l'on trouve dans l'hôpital :

- 1 à 100 lits : 280 $
- 101 à 500 lits : 365 $
- plus de 500 lits : 570 $

Les services offerts aux patients externes sont payés selon le taux fixe de 100 $ la consultation, ou de 215 $ s'il s'agit d'une hémodialyse.

Étant donné la diversité des hôpitaux que l'on trouve dans les régions rurales et les régions urbaines, le calcul de ces taux est complexe.

Les Manitobains ayant besoin de services hospitaliers jugés nécessaires du point de vue médical et qui ne sont pas offerts au Manitoba ni ailleurs au Canada peuvent être admissibles au paiement des coûts engagés aux États-Unis en fournissant à Santé Manitoba une recommandation de leur spécialiste précisant que le patient a besoin d'un service bien précis et jugé nécessaire du point de vue médical. Les services médicaux reçus aux États-Unis sont payés à un taux qui n'est pas inférieur à 100 p. 100 du taux équivalent pour le Manitoba demandé pour des services semblables. Les services hospitaliers sont payés à un taux pouvant aller jusqu'à 75 p. 100 des frais demandés par l'hôpital pour les services assurés. Les services hospitaliers sont payés en dollars américains.

Pendant l'exercice 2000-2001, Santé Manitoba a versé des paiements totalisant environ 3 500 862 $[1] pour des soins hospitaliers fournis dans des hôpitaux situés à l'extérieur du Canada. Santé Manitoba a, en outre, effectué des paiements s'élevant au total à environ 5 757 $[2] pour des services médicaux.

Dans les cas où Santé Manitoba avait obtenu une approbation préalable pour les services fournis à l'extérieur du Canada et que le paiement était inférieur au montant total facturé pour les services assurés, Santé Manitoba détermine s'il est nécessaire d'accorder des fonds supplémentaires en se fondant sur les besoins financiers.

4.4 Nécessité d'une approbation préalable

Il n'est pas nécessaire d'obtenir une approbation préalable pour les services fournis dans d'autres provinces ou territoires. Une approbation préalable est toutefois requise pour les soins hospitaliers et médicaux facultatifs

1 Ce chiffre ne comprend pas le montant payé pour combler l'écart imputable au taux de change relativement à des demandes de remboursement pour soins reçus aux É.-U.

2 Ce chiffre ne comprend pas le montant payé pour combler l'écart imputable au taux de change relativement à des demandes de remboursement pour soins reçus aux É.-U. en vertu du « Critical Shortages Fund ».

fournis à l'extérieur du Canada. Pour obtenir l'approbation, le spécialiste médical compétent doit s'adresser à Santé Manitoba.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Santé Manitoba veille à ce que les services médicaux soient assurés en toute équité et à assurer un accès équitable à tous les Manitobains. À compter du 1er janvier 1999, le Règlement sur les soins en consultation externe des établissements chirurgicaux (M.R. 222/98) pris en application de la *Loi sur l'assurance-maladie* est entré en vigueur. Il a pour objet d'empêcher les établissements chirurgicaux privés de percevoir des honoraires supplémentaires pour les services médicaux assurés.

5.2 Accès aux services hospitaliers assurés

Au 31 mars 2001, le Manitoba comptait au total 3 993 lits pour soins actifs et 703 autres lits (traitement psychiatrique prolongé, soins palliatifs, soins chroniques, évaluation de longue durée/réadaptation et à panneaux) afin de servir une population de 1 147 900 personnes.

Cinquante-six pour cent de la population manitobaine vit à Winnipeg, ville qui compte 2 271 lits pour soins actifs et 420 autres lits. Il existe, en outre, deux hôpitaux qui offrent des soins de longue durée et un établissement de soins psychiatriques pour adolescents

Dans les régions rurales du Manitoba, on compte 1 722 lits pour soins actifs et 283 autres lits. On y trouve également deux hôpitaux fédéraux et 22 postes infirmiers fédéraux. Les résidents des régions rurales du Manitoba ont, de plus, accès aux lits pour soins actifs de Winnipeg.

Comme dans les autres provinces, Santé Manitoba connaît une pénurie critique d'infirmiers et d'infirmières dans toute les régions géographiques. Le nombre d'inscriptions au programme menant au baccalauréat en sciences infirmières de l'Université du Manitoba a été augmenté et un programme de diplôme en soins infirmiers de deux ans a été rétabli. Le Manitoba jouit toutefois d'un des ratios d'infirmières autorisées par rapport à la population du pays des plus élevés (89,1 infirmières autorisées / 10 000 habitants - ICIS, 2000), mais l'âge moyen des infirmières est légèrement plus élevé que la moyenne canadienne.

On trouve également au Manitoba un très large éventail d'autres professionnels de la santé. Les pénuries dans certains domaines technologiques comme la radiothérapie, l'échographie, l'imagerie par résonance magnétique (IRM) et les techniciens de laboratoire sont également en train de devenir problématiques, le recrutement dans ces domaines étant difficile. La pénurie d'infirmières est toujours la plus critique.

À l'heure actuelle, le Manitoba a accès à trois (3) appareils à imagerie par résonance pour des essais cliniques, tous à Winnipeg. Le premier a été installé, en 1990, par la St. Boniface Research Foundation et remplacé en octobre 1998. Le deuxième appareil IRM, au Centre des sciences de la santé, fonctionne depuis septembre 1998. Cet appareil a été installé conjointement avec le Conseil national de recherches (CNR). Le troisième appareil IRM se trouve à Winnipeg depuis janvier 2000.

Le Manitoba compte 12 tomodensitomètres (scanners - TOM) : Health Sciences Centre (2), St. Boniface General Hospital (2), Victoria General Hospital, Dauphin Regional Health Centre, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia, Seven Oaks, et les hôpitaux Grace et Concordia. On trouve de plus des scanners ultrasons dans les établissements de santé de Winnipeg et dans les régions rurales et nordiques. Les essais touchant la densité osseuse menés sur deux appareils situés à Winnipeg et Brandon sont financés par Santé Manitoba.

La province a mis en œuvre un plan en cinq points destiné à améliorer l'accès aux services hospitaliers assurés. Ce plan prévoit des fonds qui permettront d'ouvrir jusqu'à 100 nouveaux lits à Winnipeg, Brandon et Thompson; d'améliorer les modalités d'admission et de congé telles que le traitement accéléré et élargi des urgences; une meilleure protection pour les soins infirmiers psychiatriques d'urgence et des équipes supplémentaires d'évaluation du programme gériatrique; un élargissement des services communautaires tels que le programme communautaire de thérapie intraveineuse, un renforcement des programmes de prévention tels que le programme de vaccination antigrippale et l'augmentation de la capacité du programme de soins à domicile et du programme de soins de jour pour adultes.

Des fonds ont été libérés pour l'achat de deux accélérateurs linéaires qui seront installés dans l'immeuble récemment rénové au site McCharles; ils ont été mis en service en décembre 2000 et en juin 2001. Ces appareils additionnels permettront d'assurer la prestation de traitement de radiothérapie de haute qualité. L'Hôpital d'oncologie de jour et de soirée a été établi dans le cadre d'efforts plus vastes visant à améliorer l'accès au traitement dans un cadre de soins appropriés. Ce programme permet aux cancéreux de suivre de longs et complexes traitements de chimiothérapie à titre de malades externes.

Le Centre de la santé du sein offre toute une gamme de services de diagnostic et d'évaluation au même endroit, y compris la mammographie diagnostique et l'écographie spécialisée pour le sein, la microbiopsie stéréotactique et la biopsie ouverte, ainsi que la consultation de chirurgiens. Ce centre offre les services suivants : éducation aux personnes et aux familles, évaluation des risques, recommandations génétiques, conseils génétiques, facilitation des essais génétiques en laboratoire touchant les femmes considérées comme ayant un risque élevé d'avoir le cancer du sein, et services d'aiguillage. Des exercices pré et post-opératoires ainsi qu'un traitement du lymphoedème sont également assurés. En outre, le modèle interdisciplinaire de soins comprend les services de travailleurs sociaux, les soins spirituels et la diététique clinique.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

En 2000-2001, Santé Manitoba a lancé plusieurs initiatives visant à améliorer l'accès aux médecins. La pénurie de médecins en régions rurales et éloignées de la province est un problème chronique. Le Manitoba a mis en œuvre un plan d'action de recrutement des médecins en régions rurales qui favorisera le recrutement d'étudiants des régions rurales, augmentera les possibilités de formation pour les étudiants en médecine et les résidents des collectivités rurales. Il compte, en outre, mettre sur pied des infrastructures permettant d'assurer une formation médicale continue.

Le Manitoba continue d'enregistrer de petites augmentations du nombre de nouveaux médecins inscrits auprès de l'organisme de réglementation professionnelle. Pour encourager le maintien en poste des diplômés du Manitoba, la province a introduit une subvention d'aide financière pour les étudiants et les résidents. En échange de l'aide financière reçue au cours de leur formation, les étudiants ou résidents acceptent de travailler au Manitoba pendant une période précise après l'obtention de leur diplôme. Le programme a été introduit en mai 2001. De plus, la province a introduit un nouveau programme pour aider les médecins du Manitoba ayant reçu leur formation à l'étranger d'obtenir leur permis d'exercice. En échange de cette aide, les médecins conviennent de travailler dans une région mal desservie de la province pendant une période précise.

5.4 Rémunération des médecins et des dentistes

En 1998, le Manitoba et l'Association dentaire du Manitoba (ADM) ont conclu un accord pour l'arbitrage des différends. Ce processus d'arbitrage a atteint son point culminant en août 1999. Le Conseil d'arbitrage a alors accordé une augmentation globale de 13,4 p. 100 pour les honoraires à l'acte, soit un montant de 33,5 millions de dollars. Il a en outre ordonné aux parties de parvenir à une entente quant à la répartition exacte de ce montant global. On a apporté la touche finale à cette entente d'allocation en février 2000. L'actuelle

entente touchant la rémunération à l'acte est en vigueur du 1er avril 1998 au 31 mars 2002. L'accord d'arbitrage continue de constituer un mécanisme de règlement des différends au Manitoba.

Les médecins sont rémunérés selon une combinaison de modalités : rémunération à l'acte, autres ententes de service, contrats indépendants, etc. En 2000-2001, aucune entente de capitation n'était en vigueur au Manitoba. Les dentistes sont rémunérés selon le principe de la rémunération à l'acte.

Le protocole d'entente est le type d'entente écrite le plus formel conclu entre Santé Manitoba et l'Association dentaire du Manitoba (ADM). Conclu à la suite de la grande décision arbitrale susmentionnée, le protocole de l'ADM a ratifié les augmentations de 13,4 p. 100 pour les actes de chirurgie buccale/dentaire et maxillo-faciale exécutés dans des établissements hospitaliers seulement. Cette entente est aussi en vigueur pour une période de quatre ans, soit du 1er avril 1998 au 31 mars 2002.

5.5 Paiements aux hôpitaux

L'article 3.1 de la *Loi sur les Offices régionaux de la santé* énonce les exigences touchant les ententes opérationnelles convenues entre les Offices régionaux de la santé et les exploitants d'hôpitaux et de foyers de soins personnels (définis comme étant des entreprises dispensant des soins de santé, aux termes de la Loi).

Selon les dispositions prévues dans ce titre, il n'est pas permis aux Offices régionaux de la santé de fournir des fonds de fonctionnement aux entreprises dispensant des soins de santé : À moins qu'elles n'aient conclu un accord écrit qui prévoit les services de santé devant être fournis par l'entremise; les fonds devant être fournis par l'office pour les services de santé, la durée de l'accord; et un processus de règlement des litiges et les recours en cas de contravention à l'accord. Si les parties ne peuvent parvenir à un accord, la Loi les autorise à demander au ministre de la Santé de nommer un médiateur afin de les aider à régler les questions en suspens. Si la médication ne permet pas de régler le litige, le ministre est habilité à régler l'affaire ou les affaires litigieuses; la décision prise par le ministre est alors exécutoire pour les parties.

Les Offices régionaux de la santé ont conclu les accords nécessaires. Les accords d'exploitation conclus entre l'Office régional de la santé de Winnipeg et les entreprises dispensant des soins de santé qui exploitent des établissements à Winnipeg prendront fin le 31 mars 2006. Ces accords d'exploitation permettent à l'Office régional de la santé de déterminer les fonds nécessaires en se fondant sur des preuves matérielles, les pratiques exemplaires et les critères couramment appliqués dans des établissements comparables.

Outre l'Office régional de la santé de Winnipeg, il existe deux autres offices régionaux de la santé où des entreprises dispensant des soins de santé exploitent des hôpitaux dans leurs régions de santé respectives (dans les autres régions, les hôpitaux sont tous exploités par les offices régionaux de la santé ou par le gouvernement fédéral). Les accords en vigueur entre les offices régionaux de la santé et les entreprises dispensant des soins de santé n'ont pas de dates d'expiration, et les offices sont habilités à déterminer les fonds à fournir chaque année.

La répartition de ressources par les offices régionaux de la santé, aux fins de la prestation de services hospitaliers, est approuvée par Santé Manitoba dans le cadre de l'approbation des plans régionaux de santé des offices. Les offices sont tenus de soumettre ces plans pour approbation conformément à l'article 24 de la *Loi sur les Offices régionaux de la santé*. Aux termes de l'article 23 de la Loi, les offices sont tenus d'affecter leurs ressources conformément au plan régional de santé approuvé.

Aux termes du paragraphe 50(2.1) de la *Loi sur l'assurance-maladie*, les paiements du Régime d'assurance-maladie du Manitoba pour les services hospitaliers assurés doivent être versés aux Offices régionaux de la santé. Quant aux hôpitaux qui sont ni possédés ni exploités par un office, l'office est tenu de payer chaque hôpital conformément à tout accord conclu entre lui et l'organisme ou la personne qui exploite l'hôpital.

6.0 Reconnaissance accordée aux transferts fédéraux

Dans les documents officiels, le Manitoba reconnaît habituellement les contributions versées par le gouvernement fédéral au titre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS). Le Manitoba ne fait pas de publicité ni ne produit de documents faisant la promotion des services de santé assurés ou des services de soins complémentaires.

7.0 Services complémentaires de santé

Le Manitoba a mis sur pied des programmes de service communautaire destinés à remplacer de façon adéquate les services hospitaliers. Ces programmes de service sont offerts par Santé Manitoba par l'entremise des Offices régionaux de la santé. Parmi ces services, mentionnons ceux qui suivent.

Services de foyers de soins personnels

Le Règlement sur l'assurance relative aux services de soins personnels et l'administration des foyers de soins personnels pris en application de la *Loi sur l'assurance-maladie*, autorise la prestation de services aux bénéficiaires des foyers de soins personnels. Ces foyers, privés et non privés, sont agréés dans la province du Manitoba par Santé Manitoba. Les bénéficiaires des foyers de soins personnels payent aussi des frais d'hébergement. Pour l'exercice 2000-2001, les dépenses de fonctionnement totales de Santé Manitoba pour les services de soins personnels se sont chiffrées à 347 695 900 $, le nombre total de lits pour soins personnels autorisés étant de 9 791. De plus, les dépenses estimatives en immobilisations et en équipement se sont élevées à 40 135 900 $.

Services de soins à domicile

Les soins à domicile Manitoba est un programme d'envergure provinciale visant à offrir des services de santé communautaires efficaces, fiables et adaptés afin de favoriser l'autonomie de la personne, l'intégration communautaire permanente et permettre de recevoir des soins en établissement lorsqu' il n'y a pas d'alternative. Les services de soins à domicile sont dispensés par l'entremise de bureaux locaux des Offices régionaux de la santé. Ils comportent une vaste gamme de services fondés sur une évaluation multidisciplinaire des besoins particuliers.

Services de soins de santé ambulatoires

La Loi sur l'assurance-maladie renferme une disposition voulant que l'on désigne comme « institution » au sens de la Loi les centres de santé ambulatoires administrés par une autorité publique sans but lucratif. On trouve environ 10 « institutions »qui reçoivent des contributions versées par Santé Manitoba.

Soins en établissement pour adultes

Les établissements de soins pour bénéficiaires internes sont des établissements communautaires fournissant l'hébergement, des soins sur place 24 heures sur 24, et assurant une surveillance et dispensant une aide pour certaines activités, de manière à répondre aux besoins particuliers des bénéficiaires. On classe ces établissements selon leur taille. Les foyers agréés peuvent compter jusqu'à trois adultes; les établissements autorisés ont un taux d'occupation de quatre adultes ou plus.

En vertu de la Loi sur les services sociaux et du Règlement du Manitoba 484/88R, les établissements de soins pour bénéficiaires internes doivent être agréés et répondre aux normes établies par la Direction de la réglementation des soins en résidence du ministère des Services à la famille et du Logement. Le règlement autorise l'agrément

d'établissements pour trois catégories d'adultes atteints d'incapacité mentale (ceux qui sont atteints de maladie mentale, ceux qui ont une incapacité mentale et ceux qui sont atteints d'incapacité en raison de l'âge).

On compte actuellement au Manitoba 98 établissements de soins pour bénéficiaires internes, agréés et autorisés, pour les personnes atteintes de maladie mentale, pour un total de 472 lits. On y trouve également 71 établissements « mixtes » disposant de 208 lits. On y dénombre 20 établissements, agréés et autorisés, pour des personnes ayant des incapacités en raison de l'âge, pour un total de 217 lits. La plupart des établissements de soins pour bénéficiaires internes sont situés à Winnipeg et Brandon.

Saskatchewan

Aperçu

Le système de santé en Saskatchewan, comme ailleurs au Canada, existe au sein d'un regroupement complexe d'initiatives des gouvernements fédéral, provinciaux et locaux, de prestation de service et de financement privés et publics et avec le soutien et le leadership d'un grand nombre de professionnels de la santé dévoués et diversifiés.

C'est en Saskatchewan que l'assurance-maladie a vu le jour. Les services hospitaliers assurés ont d'abord été offerts en Saskatchewan en 1947 et les services médicaux assurés ont été offerts pour la première fois en Saskatchewan en 1962. Le principe sous-jacent de l'assurance-maladie est que les services de santé devraient être offerts en fonction des besoins non de la capacité de payer.

De nos jours, le système de santé public offre une grande gamme de services hospitaliers, médicaux, de santé publique et mentale, de réadaptation et de lutte contre les toxicomanies et les autres substances aux résidents de la Saskatchewan sans imposer de frais directs. Le gouvernement provincial contribue également à divers autres services de soins à domicile, les services ambulanciers et pharmaceutiques, les foyers de soins spéciaux et d'autres services spécialisés dont une quote-part doit être assumée par le patient. Ces services sont offerts par l'entremise des conseils de santé de district, d'organismes associés, de médecins rémunérés à l'acte, de pharmaciens et d'autres fournisseurs de soins de santé. Le gouvernement provincial, en tant que bailleur de fonds du système de santé de la Saskatchewan, est un important déterminant dans ce secteur.

En Saskatchewan, des conseils de santé de district ont été établis pour évaluer les besoins, planifier et offrir une gamme particulière de services de santé intégrés au sein de régions désignées, notamment des services hospitaliers, des services de soins à domicile et de santé publique, des soins de longue durée et des services de promotion et de protection de la santé et de prévention des maladies.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le gouvernement provincial est responsable du financement des services hospitaliers, médicaux et de chirurgie dentaire assurés en Saskatchewan et il doit en assurer la prestation.

L'article 6.1 de *The Department of Health Act* (loi sur le ministère de la Santé) de 1978 autorise le ministre de la Santé à :

- payer en entier ou en partie le coût associé à la prestation des services de santé pour toutes les personnes ou classes de personnes pouvant être désignées par le lieutenant gouverneur en conseil;
- payer en entier ou en partie le coût associé à la prestation des services de santé dans tout district de santé ou partie de district de santé pour lequel ces services sont considérés nécessaires par le ministre;
- accorder des octrois ou subventions à tout organisme de santé si le ministre le considère nécessaire.

Les articles 8 et 9 de *The Saskatchewan Medical Care Insurance Act* (loi sur l'assurance-santé de la Saskatchewan) de 1998 donnent au ministre de la Santé le pouvoir d'établir et d'administrer un régime d'assurance-santé pour les résidents de la province.

La *The Health Districts Act* (loi sur les districts de santé) de 1993 donne au lieutenant gouverneur en conseil le pouvoir d'établir des conseils de districts de santé (article 3) et aux conseils de districts de santé, celui de dispenser les services (article 26). Trente-deux

conseils de districts de santé ont été établis; ceux-ci fournissent les services hospitaliers assurés et une gamme d'autres services de santé.

Les articles 5 et 11 de *The Cancer Foundation Act* (loi sur la fondation contre le cancer) de 1997 établissent la mise en place de la *Saskatchewan Cancer Foundation* et donnent à celle-ci le mandat de coordonner un programme de diagnostic, de prévention et de traitement du cancer.

Les mandats du ministère de la Santé, des conseils de districts de santé et de *The Saskatchewan Cancer Foundation* sont décrits dans *The Department of Health Act, The Health Districts Act* et *The Cancer Foundation Act,* tel que mentionné ci-dessus.

1.2 Liens hiérarchiques

Le ministère de la Santé est sous la responsabilité directe du ministre de la Santé, à qui il doit faire rapport de façon permanente sur le financement des services médicaux, hospitaliers et de chirurgie dentaire assurés ainsi que sur l'administration des fonds destinés à ces services.

L'article 36 de *The Saskatchewan Medical Care Insurance Act* stipule que le ministre de la Santé doit soumettre un rapport annuel sur le régime d'assurance-santé à l'assemblée législative.

La *The Health Districts Act* oblige tous les conseils de district de santé à soumettre au ministre de la Santé, dans les trois mois suivant la fin de chaque exercice financier :

- un rapport du conseil de district de santé sur les activités et coûts liés aux services;
- un ensemble détaillé d'états financiers vérifiés;
- un rapport sur l'état de santé des résidents du district de santé;
- un rapport sur l'efficacité des programmes du conseil de district de santé.

Tous les conseils de districts de santé sont tenus de soumettre à chaque année au ministère de la Santé de la Saskatchewan des plans stratégiques triennaux ainsi que des plans budgétaires annuels.

Les conseils de districts de santé consultent également de façon continue le personnel sur des questions qui préoccupent tant le conseil de district de santé que le ministre de la Santé.

En vertu de *The Cancer Foundation Act*, la fondation contre le cancer est tenue de soumettre au ministre de la Santé, au cours de chaque exercice financier, un rapport sur ses activités de même qu'un état financier pour l'exercice financier précédent.

1.3 Vérification des comptes

Le vérificateur provincial effectue une vérification annuelle des ministères et organismes gouvernementaux, dont le ministère de la Santé. Cette vérification comprend la vérification des paiements ministériels aux conseils de districts de santé, à la *Saskatchewan Cancer Foundation* ainsi qu'aux médecins et chirurgiens-dentistes pour les services médicaux et de chirurgie dentaire assurés. Le vérificateur provincial peut aussi effectuer des vérifications des conseils de districts de santé. En se fondant sur les normes professionnelles reconnues, le vérificateur provincial détermine lui-même l'étendue et la fréquence de ces vérifications.

L'article 36 de *The Health Districts Act* stipule que les comptes d'un conseil de district de santé doivent être vérifiés au moins une fois par exercice par un vérificateur indépendant qui possède les compétences requises et qui est nommé à cette fin par le conseil de district de santé. Chaque conseil de district de santé doit soumettre annuellement au ministre de la Santé un ensemble détaillé d'états financiers vérifiés.

L'article 34 de *The Cancer Foundation Act* stipule que les dossiers et les comptes de la fondation doivent être vérifiés au moins une fois l'an par le vérificateur provincial ou une personne désignée par celui-ci.

2.0 Intégralité

2.1 Services hospitaliers assurés

The Department of Health Act de 1978 impute au ministère de la Santé la responsabilité d'administrer les lois reliées à la santé (article 5) et décrit les pouvoirs et devoirs du ministre de la Santé (article 6), dont les pouvoirs de défrayer les coûts des services de santé et de financer les organismes dispensant des services de santé.

The Health Districts Act de 1993 prescrit l'établissement de conseils de district de santé responsables de la planification et de la gestion de la prestation des services de santé et elle donne au ministre de la Santé le pouvoir d'accorder des subventions aux conseils de districts de santé aux fins de la loi de même que de participer à des ententes avec les conseils de districts de santé au sujet des subventions accordées en vertu de la loi ou de toute autre question reliée aux activités ou affaires d'un conseil de district de santé.

The Saskatchewan Hospitalization Regulations ont été abrogés en 2000-2001, étant donné qu'ils n'étaient plus applicables depuis la promulgation de *The Health Districts Act*. Les règlements portaient sur l'imposition des résidents pour les services hospitaliers et les paiements aux hôpitaux. Le financement des hôpitaux est maintenant compris dans le financement octroyé aux districts de santé.

En date du 31 mars 2001, le nombre et le type d'établissements suivants fournissaient des services hospitaliers assurés à des malades hospitalisés et externes :

- soixante et huit établissements de soins actifs fournissaient des services à des malades hospitalisés et externes;
- un hôpital de réadaptation dispensait des soins pour le traitement, le rétablissement et la réadaptation de personnes devenues invalides à la suite d'une blessure ou d'une maladie. Des services de réadaptation étaient également fournis dans l'unité de réadaptation gériatrique d'un autre hôpital et de deux établissements de soins spéciaux.

The Hospital Standards Act (loi sur les normes hospitalières) et *The Hospital Standards Regulations* (règlement sur les normes hospitalières) (1980) établissent des normes minimales pour les soins ainsi que certaines exigences administratives pour les hôpitaux. Tous les hôpitaux doivent posséder les installations nécessaires à la prestation de services de traitement aux malades hospitalisés et externes et ils doivent disposer de services de diagnostic, d'une salle de radiographie et d'une chambre noire ainsi que d'une pharmacie afin de faciliter la distribution adéquate et exacte des médicaments. Au moins un membre du personnel médical doit résider dans la collectivité au sein de laquelle l'hôpital est situé. Chaque hôpital doit employer au moins trois infirmières autorisées, dont une agit comme directrice des soins infirmiers, et il doit s'assurer qu'au moins une infirmière autorisée est en poste à chaque quart de travail.

The Hospital Standards Act prévoit aussi la nomination par le ministre d'au moins un inspecteur qui vérifie et fait rapport sur les établissements approuvés en vertu de la loi (article 12). L'article 103 de *The Hospital Standards Regulations* comprend une clause mentionnant que le ministre, un inspecteur ou toute personne autorisée par le ministre peut, à tout moment, visiter un hôpital afin de s'assurer de sa conformité à la loi et aux règlements.

Le ministère incite les districts de santé à obtenir une reconnaissance du Conseil canadien d'agrément des services de santé (CCASS) pour l'ensemble du district et il les soutient dans cette démarche. Le CCASS est le principal organisme de réglementation pour les organisations du secteur de la santé au Canada. Le processus d'agrément du Conseil consiste à évaluer tous les aspects de la prestation des services de santé en adoptant une perspective axée sur le client. Les districts de santé participant évalue et compare toute leur organisation en fonction des normes de qualité nationales, afin qu'ils puissent en arriver à des programmes coordonnés, souples et appropriés pour tous les résidents. Actuellement, trente districts de santé participent au processus d'agrément du CCASS.

Les hôpitaux fournissent une gamme complète de services assurés, qui peut comprendre l'hébergement en salle commune, les services de soins infirmiers nécessaires, l'usage d'une salle d'opérations et d'une chambre d'accouchement, les matériels et appareils médicaux et chirurgicaux requis les procédures de radiographie, de laboratoire, la radiologie et les autres procédures de diagnostic, les installations de radiothérapie, les agents anesthésiques et l'usage de matériel d'anesthésie, les procédures de physiothérapie, tous les médicaments et préparations biologiques ou semblables administrés à l'intérieur de l'hôpital ainsi que les services rendus par des personnes qui reçoivent une rémunération de l'hôpital.

Il n'existe aucun registre ou liste centrale couvrant l'éventail complet des services fournis par les hôpitaux de la Saskatchewan (par exemple, il n'existe aucune liste de tous les services de soins infirmiers, de toutes les procédures de laboratoire, de radiologie et de diagnostic disponibles).

En fonction de leur évaluation des besoins en matière de santé de la population qu'ils desservent et des ressources financières dont ils disposent, les conseils de districts de santé ont le pouvoir de changer leur façon d'offrir les services hospitaliers assurés.

2.2 Services médicaux assurés

Les articles 8 et 9 de *The Saskatchewan Medical Care Insurance Act* (1998) exigent que le ministre de la Santé établisse et administre un régime d'assurance-santé pour les résidents de la province.

En avril 1999 et le 1er janvier 2001, des amendements ont été apportés à *The Physician Payment Schedule* (programme de rémunération des médecins) de *The Saskatchewan Medical Care Insurance Payment Regulations* (règlement sur les paiements au sein du régime d'assurance-santé de la Saskatchewan) conformément à l'entente prise avec la *Saskatchewan Medical Association* (association médicale de la Saskatchewan). Ces amendements sont à l'effet d'ajouter des nouveaux services médicaux assurés et de changer les niveaux de paiement pour certains services choisis.

En Saskatchewan, les médecins peuvent fournir des services médicaux assurés s'ils sont autorisés par le *College of Physicians and Surgeons of Saskatchewan* (collège des médecins et chirurgiens de la Saskatchewan) et s'ils consentent à accepter le paiement du ministère de la Santé pour les services assurés, sans imposer de surfacturation.

En date du 31 mars 2001, 1 609 médecins détenaient une autorisation d'exercer dans la province et étaient admissibles à participer au régime d'assurance-santé. L'augmentation comparativement aux années antérieures découle en partie de l'inclusion des inscriptions des suppléants exclus auparavant du nombre total de médecins en exercice.

Les médecins peuvent choisir de se retirer du *Medical Services Plan* (régime de soins médicaux) ou de ne pas y participer, mais s'ils font ce choix, ils doivent renoncer complètement à tous les services médicaux assurés. Le médecin doit aussi aviser les bénéficiaires que les services médicaux qui seront fournis ne sont pas des services assurés et que le bénéficiaire n'a pas droit au paiement de ces services. Une reconnaissance écrite du bénéficiaire mentionnant qu'il/elle comprend l'avertissement donné par le médecin est également requise.

En date du 31 mars 2001, aucun médecin de la Saskatchewan n'avait choisi de se retirer du régime.

Les services médicaux assurés sont les services médicalement nécessaires qui sont rendus par des médecins, et qui sont couverts par le régime de soins médicaux du ministère de la Santé et inscrits dans *The Physician Payment Schedule*, qui fait partie de la réglementation afférente à *The Saskatchewan Medical Care Insurance Act* intitulée *The Saskatchewan Medical Care Insurance Regulations*.

En date du 31 mars 2001, il existait environ 3 000 services médicaux assurés différents.

Les services médicaux assurés sont ajoutés au régime de soins médicaux au cours d'un processus de discussion officielle avec la *Saskatchewan Medical Association*. Le directeur administratif de la *Medical Services Branch* gère le processus d'ajout d'un nouveau service. Lorsqu'un nouveau service médical assuré devient couvert par le régime de services médicaux, un amendement obligatoire est apporté à *The Physician Payment Schedule*. Aucun nouveau service n'a été ajouté au cours de l'exercice 2000-2001.

Tout membre du public peut faire des recommandations sur les services médicaux à ajouter au régime de services médicaux, mais aucune consultation publique officielle n'est effectuée à ce sujet.

2.3 Services de chirurgie dentaire assurés

Les dentistes inscrits au *College of Dental Surgeons* (collège des chirurgiens-dentistes) de la Saskatchewan et désignés par le collège à titre de spécialistes capables d'effectuer des chirurgies dentaires peuvent offrir des services de chirurgie dentaire assurés en vertu du régime de soins médicaux.

En date du 31 mars 2001, 92 spécialistes dentaires dispensaient de tels services.

Les dentistes peuvent choisir de se retirer du régime de soins médicaux ou de ne pas y participer, mais s'ils font ce choix, ils doivent renoncer à tous les services de chirurgie dentaire assurés. Le dentiste doit aussi aviser les bénéficiaires que les services de chirurgie dentaire qui seront fournis ne sont pas assurés et que le bénéficiaire n'a pas droit au paiement de ces services. Une reconnaissance écrite par le bénéficiaire indiquant qu'il/elle comprend l'avertissement qui lui a été donné par le dentiste est également exigée.

En date du 31 mars 2001, aucun dentiste de la Saskatchewan n'avait choisi de se retirer du régime.

Les services de chirurgie dentaire assurés sont les services de chirurgie dentaire qui sont médicalement nécessaires et qui doivent être rendus dans un hôpital. Ces services comprennent, notamment :

- la chirurgie buccale qui doit être effectuée dans un hôpital et qui est nécessaire à la suite d'un trauma;
- le traitement des jeunes enfants ayant une fissure du palais;
- les soins dentaires en milieu hospitalier devant appuyer des soins médicaux-chirurgicaux (par ex. extractions lorsqu'elles sont médicalement nécessaires);
- le traitement chirurgical du dysfonctionnement de l'articulation temporo-maxillaire.

Des services de chirurgie dentaire peuvent être ajoutés à la liste de services assurés couverts par le régime de soins médicaux à la suite d'un processus de discussion et de consultation avec les chirurgiens-dentistes de la province. Le directeur administratif de la *Medical Services Branch* gère le processus d'ajout d'un nouveau service. Tout membre du public peut recommander que des services de chirurgie dentaire soient ajoutés au régime de services médicaux, mais aucune consultation publique officielle n'est tenue à ce sujet.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

En Saskatchewan, les services hospitaliers, médicaux et de chirurgie dentaire non assurés comprennent, notamment :

- les services hospitaliers donnés aux malades hospitalisés et externes pour des raisons autres que la nécessité médicale;
- les frais supplémentaires reliés à l'hébergement en chambre privée ou semi-privée non exigé par un médecin;
- les services de physiothérapie et d'ergothérapie qui ne sont pas fournis par un conseil de district de santé ou en fonction d'un contrat avec celui-ci;

- les services fournis par des établissements de santé autres que des hôpitaux, à moins que ce ne soit dans le cadre d'une entente avec le ministère de la Santé de la Saskatchewan;
- les services non urgents de traitement de la cataracte et les services non urgents d'imagerie par résonance magnétique fournis à l'extérieur de la Saskatchewan sans approbation écrite préalable;
- les services assurés hospitaliers, médicaux ou de chirurgie dentaire non urgents obtenus à l'extérieur du Canada sans approbation écrite préalable;
- les services médicaux non urgents qui ne sont pas médicalement exigés;
- les services de chirurgie dentaire qui ne sont pas médicalement nécessaires ou qui ne nécessitent pas d'être rendus dans un hôpital;
- les services couverts par la *Saskatchewan Workers' Compensation Board* (commission des accidents du travail de la Saskatchewan).

En principe et selon les politiques, les services hospitaliers, médicaux et de chirurgie dentaire assurés sont fournis en fonction d'un besoin clinique évalué. La conformité à ce principe est surveillée de façon périodique au moyen de consultations menées auprès des conseils de districts de santé, des médecins et des dentistes.

En Saskatchewan, aucuns frais ne sont exigés pour les services hospitaliers, médicaux ou de chirurgie dentaire médicalement nécessaires. Il est permis d'exiger des frais pour de meilleurs services ou produits médicaux seulement si le service ou produit médical n'est pas jugé médicalement nécessaire. La conformité est surveillée au moyen de consultations menées auprès des conseils de districts de santé, des médecins et des dentistes.

S'il évalue que certains services hospitaliers ne sont plus médicalement nécessaires, le gouvernement pourrait ne plus les assurer. Le processus serait fondé sur des discussions entre les conseils de districts de santé, des cliniciens et des fonctionnaires du ministère de la Santé.

Certains services de chirurgie dentaire assurés pourraient ne plus l'être s'ils deviennent non médicalement nécessaires ou s'ils ne doivent plus être rendus dans un hôpital. Le processus serait fondé sur des discussions et consultations avec les chirurgiens dentistes de la province et géré par le directeur administratif de la *Medical Services Branch*.

Certains services médicaux assurés pourraient ne plus l'être s'ils sont établis comme non médicalement nécessaires. Le processus serait fondé sur des consultations menées auprès de la *Saskatchewan Medical Association* et géré par le directeur administratif de la *Medical Services Branch*.

Si elles sont justifiées, il se pourrait que des consultations publiques officielles au sujet des services hospitaliers, médicaux ou de chirurgie dentaire qui pourraient ne plus être assurés soient menées.

Aucun service de santé assuré n'a été désassuré en 2000-2001.

3.0 Universalité

3.1 Admissibilité au régime

The Saskatchewan Medical Care Insurance Act (articles 2 et 12) et *The Medical Care Insurance Beneficiary and Administration Regulations* (règlement sur les bénéficiaires et l'administration du régime d'assurance-santé) établissent l'admissibilité aux services de santé assurés en Saskatchewan.

L'admissibilité est limitée aux « résidents ». Un « résident » est une personne légalement autorisée à résider au Canada qui établit son domicile en Saskatchewan et qui y est habituellement présente ou, encore, tout autre personne déclarée résidente par le lieutenant gouverneur en conseil.

Les citoyens canadiens et les résidents permanents du Canada qui viennent d'ailleurs au Canada pour s'établir en Saskatchewan sont généralement admissibles à la couverture

offerte par le régime à compter du premier jour du troisième mois suivant leur établissement de résidence en Saskatchewan.

Les Canadiens de retour au pays, les familles des membres des Forces canadiennes qui reviennent au pays, les étudiants et travailleurs étrangers sont admissibles à la couverture offerte par le régime lorsqu'ils établissent leur résidence en Saskatchewan, pourvu que cette résidence soit établie avant le premier jour du troisième mois suivant leur entrée au Canada.

Les catégories de personnes suivantes ne sont pas admissibles à la couverture des services de santé assurés en Saskatchewan :

- les personnes protégées en vertu de programmes de santé du gouvernement fédéral (c'est-à-dire les membres des Forces canadiennes et de la Gendarmerie royale du Canada (GRC), les détenus sous responsabilité fédérale, les personnes ayant demandé le statut de réfugié et les réfugiés kosovars qui sont couverts par le Programme fédéral de santé intérimaire [PFSI]);
- les visiteurs de la province;
- les personnes qui sont admissibles à la couverture offerte par leur province ou territoire de résidence pendant la durée de leur séjour en Saskatchewan (par ex. les étudiants et travailleurs couverts par leur province ou territoire de résidence en vertu de clauses d'absence temporaire).

Toutefois, ces catégories de personnes peuvent devenir admissibles s'il s'agit :

- de membres des Forces canadiennes ou de la Gendarmerie royale du Canada retirés du service, s'ils étaient en poste en Saskatchewan ou résidents de la Saskatchewan à la date de leur retraite;
- de détenus sous responsabilité fédérale, au moment de leur libération;
- de personnes ayant demandé le statut de réfugié, sur réception de leur statut de réfugié au sens de la convention (documents de l'immigration exigés);
- de réfugiés kosovars, à l'échéance de leur protection en vertu du PFSI (documents de l'immigration exigés).

3.2 Exigences relatives à l'inscription au régime

Le processus d'inscription suivant sert à émettre une carte donnant droit aux services de santé et à inscrire l'admissibilité d'une personne aux services de santé assurés :

- tout résident (autre qu'un enfant à charge de moins de 18 ans) doit s'inscrire;
- l'inscription doit avoir lieu immédiatement après l'établissement de résidence en Saskatchewan;
- l'inscription peut se faire en personne à Regina/Saskatoon ou par la poste;
- chaque personne admissible inscrite se voit remettre une carte en plastique lui donnant droit aux services de santé et portant son numéro de services de santé, numéro unique et permanent qui est composé de 9 chiffres;
- les cartes sont renouvelées tous les trois ans (les cartes actuelles viennent à échéance en décembre 2002).

Toutes les inscriptions sont fondées sur la famille. Les parents/tuteurs peuvent inscrire les enfants à charge de moins de 18 ans de leur unité familiale. Les enfants de 18 ans et plus vivant au domicile de leurs parents ou ailleurs doivent s'inscrire eux-mêmes.

Au 30 juin 2000, il y avait 1 021 762 personnes inscrites en Saskatchewan.

3.3 Autres catégories de personnes

Les autres catégories de personnes également admissibles à la couverture des services de santé assurés comprennent les personnes autorisées à entrer et à demeurer au Canada en vertu soit d'un permis de travail, d'un permis de séjour pour étudiants ou d'un permis du ministre émis par Citoyenneté et Immigration Canada. La famille qui les accompagne peut aussi être admissible à la couverture des services de santé assurés.

Les réfugiés sont admissibles sur confirmation de leur statut au sens de la convention combinée soit à un permis de travail/de séjour pour étudiants, à un permis du ministre ou à un dossier de « résident permanent » (c'est-à-dire immigrant reçu).

En date du 31 mars 2001, il y avait en Saskatchewan 3 604 de ces résidents « temporaires ».

4.0 Transférabilité

4.1 Délai minimal de résidence

En général, les personnes assurées dans une autre province ou un autre territoire qui déménagent en Saskatchewan sont admissibles à compter du premier jour du troisième mois suivant l'établissement de résidence en Saskatchewan. Cependant, quand l'un des conjoints arrive avant l'autre, l'admissibilité du conjoint arrivé le premier est établie en fonction de la date la plus tôt entre celle du premier jour du troisième mois suivant l'arrivée du second conjoint et celle du premier jour du troisième mois suivant l'établissement de résidence du premier conjoint.

4.2 Couverture durant des absences temporaires (au Canada)

L'article 3 du règlement intitulé *The Medical Care Insurance Beneficiary and Administration Regulations* afférent à *The Medical Care Insurance Act* décrit la transférabilité de l'assurance-santé fournie aux résidents de la Saskatchewan lorsqu'ils sont absents temporairement de la province mais qu'ils restent au Canada.

La couverture continue d'un résident durant une telle période d'absence temporaire de la Saskatchewan est conditionnelle à l'intention de la personne inscrite de retourner résider en Saskatchewan immédiatement après la période d'absence approuvée, selon les modalités qui suivent.

- Études : pour la durée des études dans un établissement d'enseignement reconnu (une confirmation écrite du statut d'étudiant à temps plein, émise par le registraire, est exigée annuellement).
- Emploi : jusqu'à 12 mois (aucun document requis).
- Vacances/voyage : jusqu'à 12 mois.

L'article 6.6 de *The Department of Health Act* remplace l'article 14 du *Saskatchewan Hospitalization Regulations* (règlement concernant l'hospitalisation en Saskatchewan) pour autoriser le paiement des services hospitaliers, à titre de malades hospitalisés, aux bénéficiaires de la Saskatchewan temporairement à l'extérieur de la province.

L'article 10 de *The Saskatchewan Medical Care Insurance Payment Regulations* autorise le paiement des services médicaux aux bénéficiaires de la Saskatchewan temporairement à l'extérieur de la province.

Concernant la facturation, la Saskatchewan a conclu des ententes bilatérales réciproques avec toutes les provinces pour les services hospitaliers et avec toutes les provinces sauf le Québec pour les services médicaux. Les tarifs payés sont ceux de la province hôte.

En 2000-2001, les dépenses pour les services médicaux rendus hors province ont été de 13,77 millions de dollars et celles pour les services hospitaliers rendus hors province ont été de 28,68 millions de dollars.

4.3 Couverture durant des absences temporaires (à l'étranger)

L'article 3 de *The Medical Care Insurance Beneficiary and Administration Regulations*, règlement afférent à *The Medical Care Insurance Act*, décrit la transférabilité de l'assurance-santé accordée aux résidents de la Saskatchewan lorsqu'ils sont temporairement absents du Canada.

La couverture continue des étudiants, travailleurs temporaires et vacanciers/voyageurs durant une période d'absence temporaire du Canada est conditionnelle à l'intention de la personne inscrite de retourner résider en Saskatchewan immédiatement après

la période d'absence approuvée, selon les modalités qui suivent.

- Étudiants : pour la durée des études dans un établissement d'enseignement reconnu (une confirmation écrite du statut d'étudiant à temps plein, signée par le registraire, est exigée à chaque année).
- Emploi : jusqu'à 24 mois (une confirmation écrite de l'employeur est exigée).
- Vacances/voyage : jusqu'à 12 mois.

L'article 6.6 de *The Department of Health Act* comprend les clauses selon lesquelles un résident est admissible à la couverture de l'assurance-santé lorsqu'il est temporairement à l'extérieur du Canada. En résumé, un résident est admissible aux services hospitaliers médicalement nécessaires au tarif de 100 $ par jour pour un malade hospitalisé et de 50 $ par jour pour la visite d'un malade externe. L'article 6.6 de *The Department of Health Act* remplace l'article 15 du *Saskatchewan Hospitalization Regulations* qui prévoyait la couverture de l'assurance-santé aux bénéficiaires de la Saskatchewan résidant temporairement à l'extérieur de la province.

En 2000-2001, la somme de 1 022 000 $ a été payée pour les services hospitaliers fournis aux malades hospitalisés et la somme de 377 600 $ a été dépensée pour les services hospitaliers donnés aux malades externes.

4.4 Nécessité d'une approbation préalable

À l'extérieur de la province

Le ministère de la Santé de la Saskatchewan couvre la plupart des soins hospitaliers et médicaux reçus au Canada par les résidents de la province par le truchement d'une entente de facturation réciproque. Grâce à cette entente, les résidents n'ont pas besoin d'une approbation préalable et ne seront pas facturés pour la plupart des services reçus dans les autres provinces ou territoires lors de voyages au Canada. Les frais de déplacement, les repas et l'hébergement ne sont pas couverts.

Les services médicaux reçus au Québec – l'entente de facturation réciproque pour les services médicaux s'appliquent à toutes les provinces à l'exception du Québec. Les factures des médecins sont soumises et le ministère de la Santé de la Saskatchewan rembourse les services assurés obtenus au Québec aux taux fixés en Saskatchewan. Toutefois, les services seront remboursés aux taux du Québec si une approbation préalable est accordée.

Une approbation préalable est requise pour les services suivants offerts à l'extérieur de la province :

- traitement pour alcoolisme ou toxicomanie, services de santé mentale et pour joueurs compulsifs;
- chirurgie de la cataracte, ostéodensitométrie, et imagerie par résonnance magnétique (IRM), étant donné que le ministère de la Santé de la Saskatchewan ne couvre pas habituellement ces services s'ils sont obtenus à l'extérieur de la province.

Avant que le ministère de la Santé ne finance ces services reçu par un résident de la Saskatchewan dans une autre province ou un territoire, une approbation préalable doit être obtenue du ministère par le spécialiste du patient.

À l'extérieur du pays

Une approbation préalable est requise pour les services suivants offerts à l'extérieur du pays :

- Si un médecin spécialiste réfère un patient à l'extérieur du Canada pour un traitement non disponible en Saskatchewan ou dans une autre province, le médecin doit d'abord demander une approbation du régime de soins médicaux du ministère de la Santé de la Saskatchewan. Les demandes de traitement du cancer à l'extérieur du pays doivent être approuvées par la *Saskatchewan Cancer Agency*. Si l'approbation est accordée, le ministère de la Santé de la Saskatchewan couvrira les coûts du traitement, à l'exception de tout élément non couvert en Saskatchewan.

- Le ministère de la Santé de la Saskatchewan ne couvre pas habituellement les services non urgents, qu'il s'agisse de soins hospitaliers ou médicaux, de services d'optométrie ou de chiropractie. Une approbation préalable est donc requise.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Afin de garantir que l'accès aux services hospitaliers, médicaux et de chirurgie dentaire assurés n'est pas entravé ou empêché à cause d'obstacles financiers, la surfacturation par les médecins ou les chirurgiens dentistes et l'exigence de frais modérateurs par les hôpitaux ne sont pas permises en Saskatchewan.

The Saskatchewan Human Rights Code (charte des droits de la personne de la Saskatchewan) interdit la discrimination dans la prestation de services publics (ce qui inclut les services de santé assurés) fondée sur la race, la croyance, la religion, la couleur, le sexe, l'orientation sexuelle, la situation de famille, l'état matrimonial, l'invalidité, l'âge, la nationalité, l'ascendance ou le lieu d'origine.

5.2 Accès aux services hospitaliers assurés

En date du 31 mars 2001, la Saskatchewan comptait 68 hôpitaux de soins actifs, avec une capacité de 3 307 lits (2 802 lits pour soins actifs, 203 lits pour soins psychiatriques et 302 autres lits).

L'hôpital Wascana Rehabilitation disposait de 118 lits pour soins de réadaptation, de 109 lits pour soins prolongés et de 80 autres lits pour soins de longue durée. Des soins de réadaptation sont également offerts dans une unité de réadaptation gériatrique d'un centre hospitalier de soins actifs et dans deux établissements de soins spécialisés.

Le ministère ne recueille pas d'information sur les lits pour soins actifs utilisés pour les services en clinique externe.

Des données couvrant l'ensemble de la province et provenant d'une enquête menée auprès des employeurs en santé, la *Provincial Health Employer Survey*, indiquent que tout au long des années 1990, le nombre de professionnels de la santé à l'emploi du système de santé provincial a augmenté légèrement, mais de façon constante. Dans presque tous les cas, le nombre de professionnels de la santé pratiquant dans la province a augmenté tout au long de la dernière décennie. Au cours de cette période, le nombre d'infirmières autorisées et d'infirmières auxiliaires autorisées a diminué (d'environ 6,5 p. 100 pour les infirmières autorisées et d'environ 19 p. 100 pour les infirmières auxiliaires autorisées). La population de la Saskatchewan n'a pas changé de façon substantielle au cours de la même période, bien que la proportion de la population âgée de 75 ans et plus ait augmenté, passant de 5,9 p. 100 à 7,3 p. 100 de la population assurée.

La banque de données sur les infirmières autorisées de l'Institut canadien d'information sur la santé indique qu'en 2000, le rapport d'infirmières autorisées envers la population de la Saskatchewan (835/100 000) était similaire à celui des autres provinces et plus élevé que le taux pour l'ensemble du Canada (754/100 000).

Au cours des quelques dernières années, les hôpitaux ont manqué de personnel infirmier, particulièrement d'infirmières possédant une formation spécialisée leur permettant de travailler dans des domaines comme les salles d'opérations, les soins intensifs et la dialyse.

Les initiatives suivantes ont été mises en oeuvre pour améliorer le recrutement et favoriser la rétention du personnel infirmier :

- À l'automne 2000, 280 étudiants se sont inscrits à la première année du programme de formation du personnel infirmier de la Saskatchewan (inf. aut., inf. psy. aut.) une hausse de 100 inscriptions comparativement à l'année précédente.

- En avril 2000, la province a annoncé un programme de bourse pour les infirmières désireuses de réintégrer leurs professions respectives (c.-à-d. inf. aut., inf. aux. aut., inf. psy. aut.).
- En juillet 2000, une conseillère principale en soins infirmiers pour la Saskatchewan a été nommée pour conseiller le ministre et la sous-ministre et partager son expertise avec eux sur les questions touchant les politiques et les programmes connexes aux soins infirmiers, et travailler avec les professionnels de la santé, les employeurs, les organismes de réglementation professionnelle et les syndicats afin de traiter des questions concernant les soins infirmiers.
- Parmi les autres initiatives notons des projets-pilotes pour créer des environnements de travail spécialisés, traiter des questions relatives à la main-d'oeuvre occasionnelle dans des unités de soins infirmiers particulières (p. ex. congés de maladie, pratiques d'embauche et coûts des heures supplémentaires) et du mentorat des étudiants en soins infirmiers au cours de leurs travaux cliniques.

En ce qui a trait à la disponibilité du matériel et des services choisis pour le diagnostic, les soins médicaux, la chirurgie et le traitement dans les établissements fournissant les services hospitaliers assurés :

- les appareils d'imagerie par résonance magnétique (IRM) sont situés à Saskatoon (2) et à Regina (1);
- les appareils de tomodensitométrie sont disponibles à Saskatoon (3), à Regina (3), à Prince Albert (1) et à Swift Current/Moose Jaw (1);
- la dialyse rénale est offerte à Saskatoon, à Regina, à Lloydminster, à Prince Albert, à Tisdale, à Yorkton et à Swift Current;
- le traitement du cancer est offert à Saskatoon et à Regina où sont situés des centres anticancéreux. Plus de 46 000 traitements du cancer sont offerts à 4 500 patients en moyenne aux centres de traitement de Saskatoon et de Regina;
- dix-neuf districts de santé participent à un programme communautaire d'oncologie qui permet aux malades de recevoir de la chimiothérapie et d'autres soins de soutien plus près de leur domicile, tout en maintenant un lien étroit avec les experts des centres anticancéreux de Regina et de Saskatoon;
- environ 70 p. 100 des services de chirurgie sont fournis à Saskatoon et à Regina, où sont en place des médecins et du personnel spécialisés ainsi que l'équipement permettant d'offrir une gamme complète de services chirurgicaux; cinq hôpitaux de taille moyenne situés à Prince Albert, Moose Jaw, Yorkton, Swift Current et North Battleford offrent un pourcentage additionnel de 22 p. 100 des services de chirurgie; les services qui restent sont offerts dans de plus petits hôpitaux de l'ensemble de la province;
- des liens de télésanté ont été établis pour permettre aux résidents d'un certain nombre de régions rurales et éloignées d'accéder à un spécialiste, à un médecin de famille et à d'autres fournisseurs de services de santé sans qu'ils aient à se déplacer sur de longues distances.

En 2000-2001, un certain nombre de mesures ont été prises pour améliorer l'accès aux services hospitaliers assurés.

- L'accès aux services d'imagerie médicale spécialisée, notamment IRM, test de tomodensitométrie et de teneur minérale de l'os, ont pris de l'ampleur en Saskatchewan au cours de l'exercice 2000-2001. Au cours de cette période, environ 12 000 IRM ont été effectuées, ce qui représente une hausse de 30 pour cent comparativement à l'année précédente; environ 62 000 tests de tomodensitométrie a été effectués, ce qui correspond à une hausse de 15 pour cent comparativement à l'année précédente et au double du nombre de tests faits en 1992-1993.
- En octobre 2000, le district de santé de Regina a commencé à offrir un service de tests de la teneur minérale de l'os afin de servir les résidents du sud de la Saskatchewan. Auparavant, seul le district de santé de Saskatoon était en mesure d'offrir ce service dans la province.
- Le 30 juin 2000, le Réseau de télésanté du nord (RTN), projet-pilote de 12 mois, a pris fin. Le RTN est un partenariat entre le

ministère de la Santé de la Saskatchewan et six districts de santé. Une évaluation externe a établi que le réseau a amélioré l'accès aux services pour les patients/clients, particulièrement en pédopsychiatrie et en dermatologie. Le nombre de cliniques spécialisées dans le nord est demeuré stable ce qui veut dire que le RTN a facilité l'accès aux spécialistes sans augmenter leurs déplacements.

- Le RTN s'est avéré un outil efficace pour la consultation clinique et le perfectionnement professionnel dans le nord de la Saskatchewan. Le ministère de la Santé de la Saskatchewan continuera d'appuyer le réseau et a demandé du financement pour l'exercice 2000-2001 à Santé Canada dans le cadre du Programme des partenariats pour l'infostructure canadienne de la santé (PPICS) dans le but d'élargir la portée du programme au reste de la province.
- La *Saskatchewan Cancer Agency* a continué d'étendre son programme communautaire d'oncologie. En 2000-2001, le programme a été étendu et, maintenant, 19 districts de santé y participent. Ce programme permet aux malades de recevoir de la chimiothérapie et d'autres soins de soutien plus près de leur domicile, tout en maintenant un lien étroit avec les experts des centres anticancéreux de Regina et de Saskatoon. Une évaluation du programme devrait être terminée à l'automne 2001.
- En 2000-2001, le ministère de la Santé de la Saskatchewan a versé un montant de 4,2 million de dollars en contribution pour l'achat d'un nouvel accélérateur linéaire destiné au centre anticancéreux de Saskatoon. La construction d'une enceinte spéciale pour abriter le matériel a commencé en avril 2001 et le nouvel accélérateur linéaire devrait être installé et opérationnel d'ici le printemps 2002.
- À la suite de son succès dans le traitement de la maladie de Hodgkin et des autres types de lymphomes, le programme de greffe de cellules souches du sang périphérique destiné aux malades cancéreux a bénéficié d'un financement accru pour qu'il prenne de l'expansion afin d'inclure les malades souffrant de myélopathie et de leucémie. L'expansion de ce service spécialisé permet à un plus grand nombre de malades cancéreux d'être traités efficacement plus près de leur domicile, ce qui réduit le fardeau financier et émotif associé à la nécessité d'avoir à se déplacer sur de longues distances pour recevoir un traitement. Depuis la création du programme en 1998, 112 patients ont été référés au programme de cellules souches.
- La *Cancer Agency* est responsable du programme provincial de dépistage du cancer du sein. Le programme de dépistage est réparti entre sept sites permanents dans la province et une unité mobile de mammographie qui se rend dans les collectivités non desservies par un site permanent. Le programme de dépistage a le plus haut taux de participation au Canada; quelque 36 400 femmes par année sont examinées.

Le ministère de la Santé de la Saskatchewan a consacré beaucoup de temps et de ressources en vue de résoudre la question concernant les listes d'attente. Guidé par les recommandations du *Task Team on Surgical Waiting Lists*.(mars 1999), le ministère a continué a travaillé en collaboration avec tous les partenaires du secteur de la santé afin d'améliorer l'accès aux services de chirurgie dans la province.

En août 1999, le gouvernement provincial a établi un fonds de 12 millions de dollars consacré aux listes d'attente, afin de résoudre les problèmes reliés aux listes d'attente et de réduire les temps d'attente pour l'obtention des services assurés. Le fonds de 2000-2001 a été élargi de manière à inclure Prince Albert et Moose Jaw tandis que les investissement se sont poursuivis à Saskatoon et à Regina. Les fonds ont été utilisés par les quatre plus importants districts de santé :

- pour acheter de l'équipement supplémentaire essentiel à la chirurgie;
- pour augmenter le temps de salle d'opération disponible en modifiant la répartition du personnel et en déplaçant certaines procédures, de la salle d'opération vers les soins ambulatoires;
- pour financer des initiatives de recrutement du personnel, de maintien de l'effectif et de formation;

- pour mettre en place une série d'initiatives de coordination et de gestion de l'utilisation.

En 2000-2001, le ministère de la Santé de la Saskatchewan a continué à participer au projet des listes d'attente de l'Ouest du Canada en collaboration avec 19 organisations partenaires des quatre provinces de l'Ouest. Le projet favorise la collaboration avec les groupes intéressés (p. ex. les médecins, le public, les autorités sanitaires régionales, les gouvernements) en vue d'élaborer et de mettre à l'essai des outils d'évaluation clinique. Ces outils permettront aux médecins de revoir la priorité concernant les patients en attente des interventions médicales suivantes : remplacement total ou partiel de la hanche ou du genou, la chirurgie de la cataracte, une chirurgie générale, des services de pédopsychiatrie et des services d'IRM.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

En date du 31 mars 2001, il y avait, en Saskatchewan, 1 609 médecins actifs (définis comme gagnant au moins 10 000 $ par trimestre sur une base de rémunération à l'acte). De ce nombre, 1 016 (63,1 p. 100) étaient des médecins de famille et 593 (36,9 p. 100) étaient des spécialistes.

En date du 31 mars 2001, environ 398 dentistes et chirurgiens dentistes pratiquaient dans tous les principaux centres de la Saskatchewan. Quatre-vingt-douze dentistes offraient des services assurés en vertu du régime de soins médicaux.

En 2000-2001, un certain nombre d'initiatives visant à améliorer l'accès aux services médicaux assurés et à réduire les temps d'attente pour les services médicaux étaient en cours. Celles-ci comprenaient, entre autres, les suivantes :

- Programme de maintien en poste à long terme – ce programme récompensera les médecins qui travaillent dans la province pour au moins dix ans.
- Programme de formation et réintégration – ce programme accorde annuellement deux bourses à des médecins de famille ruraux qui souhaitent suivre une formation spécialisée, à la condition que les médecins s'engagent à retourner à leur travail par la suite.
- Financement pour le recrutement et le maintien en poste de spécialistes (nouveau) – offrant un financement pour de nouvelles initiatives en plus du financement déjà offert aux districts de santé de Regina et de Saskatoon.
- Coordonnateur du recrutement des médecins — un coordonnateur du recrutement des médecins assiste les districts ruraux et les médecins dans le recrutement de médecins.
- Programme de couverture des salles d'urgences et de répit durant les fins de semaine – les médecins ruraux sont soutenus par un programme intégré de couverture des salles d'urgences et de répit durant les fins de semaine pour lequel un financement annuel de 6,8 millions de dollars sert à rémunérer les médecins qui fournissent une couverture des salles d'urgences dans les régions rurales et à aider les collectivités disposant de moins de trois médecins à embaucher d'autres médecins pour donner un répit durant les fins de semaine aux médecins en place.
- Programme de subventions pour l'établissement d'une pratique rurale – ce programme met des subventions de 18 000 $ à la disposition de médecins formés au Canada ou reçus comme immigrants qui établissent, pour un minimum de 18 mois, de nouveaux cabinets dans les régions rurales de la Saskatchewan.
- Programme de bourses d'études pour médecins résidents – ce programme fournit des bourses d'études de 18 000 $ à trois médecins de famille résidents afin de les aider à faire face aux dépenses reliées à la formation médicale en retour d'un engagement à servir dans un milieu rural.
- Programme de bourses d'études pour étudiants en médecine du premier cycle – ce programme offre une bourse annuelle de 18 000 $ aux étudiants en médecine qui, en retour, s'engagent par écrit à oeuvrer dans une collectivité rurale.

- Formation pour l'amélioration de la pratique rurale – ce programme fournit un remplacement du revenu aux médecins ruraux pratiquants et une assistance aux médecins résidents qui désirent suivre une formation spécialisée dans un domaine en demande dans les régions rurales de la Saskatchewan. Un engagement de retour de service est exigé.
- Programme d'éducation médicale continue sur les urgences en milieu rural – ce programme fournit des fonds aux médecins ruraux désirant obtenir une attestation de certification ou de recertification de leurs compétences en soins d'urgence et en gestion du risque. Les médecins acceptés sont tenus d'offrir leurs services dans une région rurale de la Saskatchewan après avoir terminé un programme éducatif.
- Programme de répit durant les fins de semaine accordé par des médecins résidents – ce programme assortit des résidents de deuxième année en médecine familiale à des médecins des plus grandes collectivités rurales qui désirent obtenir un répit durant les fins de semaine.
- Programme de service de suppléance – la *Saskatchewan Medical Association* reçoit un financement pour offrir un service de suppléance afin d'accorder un répit aux médecins lorsqu'ils prennent un congé pour des vacances, de la formation ou autre.
- Services d'autres modes de paiement et de soins primaires – un soutien est accordé aux initiatives incitant les médecins à recourir à des professionnels de la santé associés et favorisant l'amélioration de l'intégration des services médicaux aux autres services communautaires.
- Programme de services médicaux du Nord – ce programme est une tentative tripartite du ministère de la Santé de la Saskatchewan, de Santé Canada et de l'Université de la Saskatchewan pour aider à stabiliser la disponibilité en médecins dans le nord de la Saskatchewan.
- Programme rural de congé prolongé – ce programme soutient les médecins pratiquant en milieu rural qui veulent mettre à jour leurs compétences et leurs connaissances dans des domaines comme l'anesthésie, l'obstétrique et la chirurgie, en leur remboursant les frais de scolarité et le manque à gagner pour une période allant jusqu'à six semaines.
- Programme d'aide de voyage en milieu rural – ce programme fournit une aide de voyage aux médecins en régions rurales qui participent à des activités éducatives.
- Réseau de télésanté du Nord – ce réseau de télésanté fournit aux médecins des régions éloignées ou isolées un accès à des collègues, à une expertise spécialisée et à de l'éducation permanente.

5.4 Rémunération des médecins

Le processus de négociation avec les médecins et dentistes des ententes sur la rémunération des services assurés est décrit dans *The Saskatchewan Medical Care Insurance Act*, comme suit :

- un comité d'étude de la rémunération médicale est mis sur pied dans les quinze jours de l'avis émis soit par la *Saskatchewan Medical Association* ou le gouvernement à l'effet de commencer les discussions sur une nouvelle entente;
- chaque partie ne doit pas nommer plus de six représentants au comité;
- l'objectif du comité est de préparer une entente satisfaisante pour les parties en ce qui concerne les services assurés;
- dans le cas où une entente satisfaisante ne peut pas être atteinte, la question peut être référée au conseil d'étude de la rémunération médicale, qui est formé d'une personne nommée par chaque partie; ces personnes choisissent, tour à tour, un troisième membre;
- le conseil a le pouvoir de prendre des décisions qui lie les parties en cause.

En décembre 2000, une nouvelle entente de trois ans (rétroactive au 1er avril 2000) a été négociée avec succès avec la *Saskatchewan Medical Association*. Elle prévoit une hausse de trois pour cent par année au *Physician Payment Schedule*. Des hausses similaires ont aussi été accordées aux médecins non rémunérés à l'acte. En outre, un financement accru a été

accordé pour de nouveaux items et la modernisation du barème des paiements.

L'article 6 de *The Saskatchewan Medical Care Insurance Payment Regulations* décrit l'obligation du ministre de la Santé d'effectuer le paiement des services assurés conformément au *Physician Payment Schedule* et au *Dentist Payment Schedule*.

La formule de rémunération à l'acte est la méthode la plus largement utilisée de rémunération des médecins pour les services de santé assurés en Saskatchewan, bien que les méthodes de rémunération à la vacation, de paiement de salaire, de paiement par capitation et d'un mélange de ces méthodes soient également utilisées. La méthode de rémunération à l'acte est le seul mécanisme de paiement des dentistes pour les services de chirurgie dentaire assurés.

5.5 Paiements aux hôpitaux

En 1994 et 1995, la Saskatchewan a adopté une approche fondée sur les besoins de la population. Dans cette approche, le financement est alloué aux conseils de districts de santé en fonction des caractéristiques de la population qui déterminent les besoins de services. Chaque conseil de district de santé reçoit un budget global établi par un large secteur de services (par ex., soins actifs institutionnels – hôpitaux; interventions de soutien en institution; services à domicile) et a la responsabilité d'allouer les fonds de ce budget afin de répondre aux besoins de services et aux priorités déterminés au moyen de ses processus d'évaluation des besoins. Les districts peuvent recevoir des fonds additionnels pour la réalisation de programmes hospitaliers spécialisés (par ex., dialyse rénale, services spécialisés d'imagerie médicale et services respiratoires spécialisés) ou pour la prestation de services aux résidents d'autres districts de santé.

Les paiements aux districts de santé pour la prestation de services sont effectués en vertu de la *Health Districts Act* (1993). Cette loi donne au ministre de la Santé le pouvoir d'accorder des subventions aux conseils de districts de santé aux fins de la loi et de signer des ententes avec les conseils de districts de santé, dans le respect des subventions accordées en vertu de la loi ou pour tout autre question reliée aux activités ou aux affaires d'un conseil de district de santé.

Le financement des districts, y compris la plus grande partie du financement des services hospitaliers assurés, est fourni en fonction de l'approche fondée sur les besoins décrite ci-devant.

Les districts peuvent recevoir des fonds additionnels pour la réalisation de programmes hospitaliers spécialisés, tels que la dialyse rénale, les services spécialisés d'imagerie médicale et les services respiratoires spécialisés.

En 2000-2001, les fonds destinés à régler les problèmes de listes d'attente pour ceux qui doivent subir une opération chirurgicale ont été alloués aux quatre plus grands districts de santé. On a demandé à chaque district de présenter un montant maximal à dépenser pour l'équipement essentiel et un plan d'allocation de l'équipement, le reste des fonds devant servir à des initiatives opérationnelles visant à augmenter la capacité chirurgicale et le débit. Les districts ont dû rapporter toutes les dépenses et tous les changements en ce qui concerne les volumes de services résultant du financement additionnel.

Annuellement, les conseils de districts de santé produisent un rapport sur les résultats financiers totaux de leurs opérations.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement de la Saskatchewan a reconnu publiquement les contributions fédérales fournies au titre du Transfert canadien en matière de santé et de programmes sociaux dans le rapport annuel de 2000-2001 du ministère de la Santé, le budget annuel 2000-2001 et dans les documents connexes, dans ses Comptes publics 2000-2001 et dans son rapport financier de la mi-année. Ces documents ont été déposés à l'Assemblée législative et mis à la disposition des résidents

de la Saskatchewan. Les contributions fédérales ont aussi été reconnues par l'entremise du site Web du ministère de la santé de la Saskatchewan, de communiqués de presse, de documents de discussion, de discours et de remarques faites au cours de diverses conférences, réunions et tribunes sur la politique publique. (Voir la section des documents supplémentaires.)

7.0 Services complémentaires de santé

En date du 31 mars 2001, l'éventail des services de santé complémentaires offerts par le gouvernement provincial comprenait un régime de médicaments d'ordonnance, le *Saskatchewan Aids to Living Independent Living Program* (qui fournit des matériels et appareils médicaux aux personnes handicapées), le *Supplementary Health Program* (qui offre des services de santé non assurés aux personnes désignées par les services sociaux de la Saskatchewan), le *Family Health Benefits Program* (qui offre des services de santé non assurés surtout aux enfants de familles de travailleurs à faible revenu), un programme d'éducation dentaire pour enfants, un programme de prothèses auditives, une couverture limitée des services rendus par les chiropraticiens, les optométristes et les podologues, des services de soins à domicile, des services de soins de longue durée, des services ambulanciers aériens et routiers, des services de cliniques communautaires et de centres de santé communautaires, des services de toxicomanie, des services de santé mentale et des soins d'ergothérapie et de physiothérapie.

Services de soins courants dans les foyers de soins infirmiers

- Les foyers de soins spéciaux offrent des services de soins de longue durée pour répondre aux besoins des personnes qui ont habituellement des besoins de soins assidus. Les services offerts comprennent des soins et l'hébergement, des soins de relève, des programmes de jour, des soins de nuit, des soins palliatifs et, dans certains cas, des services de convalescence. Ces établissements sont financés par l'État par l'entremise des conseils de santé de district et sont régis conformément à *The Housing and Special-care Homes Act*.
- Le programme provincial d'immunisation prévoit l'immunisation des résidents des établissements de soins de longue durée et autres établissements résidentiels semblables. Le ministère de la Santé de la Saskatchewan achète les vaccins et les offrent gratuitement aux départements de santé publique de district qui à leur tour les offre aux établissements locaux de soins de longue durée et aux autres établissements du genre. Ceci s'applique aux vaccins antigrippal et antipneumococcique.

Services offerts dans des établissements de soins spéciaux pour adultes

Services de santé mentale

- Des foyers de groupe offrent une aide permanente aux personnes atteintes d'une maladie mentale de longue durée et sont régis par *The Mental Health Services Act* et *The Residential Services Act*.
- Le ministère de la Santé de la Saskatchewan, en partenariat avec le district de santé Midwest, offre un programme de réadaptation aux personnes et aux familles aux prises avec des troubles de l'alimentation. Le centre BridgePoint offre ce programme qui est actuellement régi par *The Non-profit Corporations Act* et *The Co-operatives Act*.

Services aux alcooliques et aux toxicomanes

- Services aux alcooliques et aux toxicomanes Les services aux alcooliques et aux toxicomanes relèvent habituellement de *The Health Districts Act*. Les établissements qui offrent des services résidentiels aux alcooliques et aux toxicomanes sont autorisés de la façon indiquée ci-dessous. Le ministère de la Santé de la Saskatchewan ou les districts de santé

communiquent avec des organisations communautaires à but non lucratif pour offrir des services et sont régies par de *The Non-profit Corporations Act*.

- Les services de désintoxication fournissent un environnement sûr et positif dans lequel le client peut entreprendre un processus de sevrage de l'alcool ou d'autre drogue et de stabilisation. Hébergement, repas et groupes d'entraide sont offerts pour une période maximale de dix jours. Les services de désintoxication sont régis par *The Housing and Special-care Homes Act*.
- Des services hospitaliers sont offerts aux personnes qui sont préoccupées par leur propre consommation d'alcool ou de drogues ou par celle d'autres personnes. Les services offerts comprennent des évaluations, du counselling, des programmes d'éducation et d'entraide pour une période de quatre semaines ou plus selon les besoins de la personne. Les services hospitaliers sont régis par *The Housing and Special-care Homes Act*.
- Les services d'hébergement de longue durée offrent des services pour une période prolongée aux personnes qui sont aux prises avec une chiomiodépendance et une toxicomanie. Ces établissements offrent des services de consultation, des programmes d'éducation et de prévention des rechutes dans un environnement sûr et positif. Les services d'hébergement de longue durée sont régis par *The Housing and Special-care Homes Act*.

Services de soins à domicile

- Le programme de soins à domicile représente une option pour les personnes qui ont une maladie ou une invalidité de courte ou de longue durée qui peuvent demeurer dans leurs propres maisons plutôt qu'être admises dans un établissement de soins. Le programme de soins à domicile est conçu pour fournir des soins et des services aux personnes qui ont besoin de soins palliatifs, de soins de courte durée ou de soutien. Les services comprennent l'évaluation et la coordination des soins, des soins infirmiers, des soins personnels, des soins de relève, des services d'entretien, de repas, d'entretien ménager, des services thérapeutiques et bénévoles. Le programmes est régi par *The Home Care Act* (qui devrait être abroger bientôt) et *The Health Districts Act*.

Service de soins ambulatoires

- Les districts de santé de la Saskatchewan offrent aux collectivités une gamme complète de services de santé mentale et de services aux alcooliques et aux toxicomanes. Les services de santé mentale sont offerts conformément à *The Mental Health Services Act*.
- La plupart districts de santé de la Saskatchewan offrent des services de podologie qui comprennent des services d'évaluation, de consultation et de traitement. Ce programme est administré conformément à *The Health Districts Act*.
- Les districts de santé de la Saskatchewan offrent un programme de prothèses auditives qui comprend des services de dépistage de la surdité, d'évaluation des enfants à risque, ainsi que de vente, d'ajustement et d'entretien de prothèses auditives. *The Health Districts Act* et *The Speech Language Pathologists and Audiologists Act* régissent ces programmes.
- Des thérapies communautaires, y compris des services d'ergothérapie et de physiothérapie, sont offertes par les districts de santé de la Saskatchewan et viennent en aide à des gens de tous les âges afin d'améliorer leur indépendance fonctionnelle. Les services sont offerts dans des établissements, des écoles, des hôpitaux et des résidences privées et comprennent l'évaluation, la consultation et le traitement. Le programme est administré conformément à *The Health Districts Act*.

Documents supplémentaires présentés à Santé Canada

- *Saskatchewan Health Annual Report, 1999-2000*
- *Medical Services and Health Registration Branch Annual Report, 1999-2000*
- *Saskatchewan Finance Backgrounder – 2001-2002 CHST*
- Partners in Health – Our Other Partners
- *Health Services Opportunities Conference – November 25, 2000*
- Speaking Notes for the Minister of Health
- *The Non-Profit Corporations Act, 1995*
- *The Speech-Language Pathologists and Audiologists Act*
- *The Home Care Act*
- *The Co-operatives Act, 1996*
- *The Cancer Foundation Act*
- *The Housing and Special-care Homes Act*
- *The Mental Health Services Act*
- *The Residential Services Act*
- *The Housing and Special-care Homes Regulations*
- *General Regulations under The Cancer Control Act*
- *The Dental Care Beneficiary Regulations, 1987*
- *The Dental Care Act*
- *The Hospital Standards Act*
- *The Hospital Standards Regulations, 1980*
- *The Department of Health Act*
- *The Saskatchewan Medical Association Dues Check-off Regulations, 1996*
- *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*
- *The Saskatchewan Medical Care Insurance Act*
- *The Optometric Services Payment Negotiation Regulations, 1988*
- *The Medical Care Insurance Peer Review Regulations*
- The Medical Care Insurance Beneficiary and Administration Regulations
- The Chiropractic Services Payment Negotiation Regulations
- The Insured Services (Physicians) Payment Schedule Review Regulations, 1989
- *The Insured Services (Physicians) Access Regulations, 1987*
- *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*
- *The Medical Care Insurance Beneficiary and Administration Regulations*
- *The District Health Boards Election Regulations*
- *The Health Districts Act*
- Budget de la Saskatchewan 2000-2001 et 2001-2002 à www.gov.sk.ca/finance/budget
- Comptes publics 2000-2001 à www.gov.sk.ca/finance/paccts/default.htm

Alberta

Aperçu

Le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta comprend le ministère de la Santé et du Mieux-être (le ministère) et l'*Alberta Alcohol and Drug Abuse Commission* (AADAC). Le ministère est composé de six divisions et de 28 directions générales.

Mission

La mission du portefeuille ministériel consiste à diriger et à appuyer un système chargé de la prestation de services de santé de qualité et à favoriser et à appuyer un style de vie sain. La vision du ministère est *l'optimisation de la santé et du mieux-être passe par les citoyens d'une province en santé*.

En plus des principes décrits dans la *Loi canadienne sur la santé*, le ministère est engagé à fournir un système de santé qui :

- témoigne de l'excellence – des normes élevées et des pratiques exemplaires sont obtenues par l'entremise de la recherche, de l'éducation et de l'information;
- donne un accès équitable à tous les Albertains à une gamme complète de services de santé intégrés;
- offre des services de qualité et des résultats efficaces;
- favorise la responsabilité et la prise de décision partagées entre les utilisateurs et les fournisseurs;
- assure la responsabilisation, à tous les niveaux, pour les résultats;
- est rentable et viable à long terme.

En plus de respecter les exigences particulières de la *Loi canadienne sur la santé*, le ministère offre aussi une couverture complète ou limitée pour un certain nombre d'autres services de santé, tels que :

- les soins à domicile et les soins de longue durée;
- les services de santé mentale;
- la prestation d'assurance-santé complémentaire aux aînés, aux bénéficiaires des rentes au conjoint de l'Alberta (et les personnes à charge des deux);
- les soins palliatifs;
- les programmes d'immunisation à l'intention des enfants;
- certains services paramédicaux, tels que l'optométrie (pour les résidents de moins de 19 ans et de plus de 65 ans), la chiropractie, la podologie, etc.

Autorités sanitaires régionales et autorités sanitaires provinciales

En Alberta, 17 autorités sanitaires régionales et deux autorités sanitaires provinciales assurent la prestation de services de santé. Les autorités sanitaires régionales sont responsables des hôpitaux, des établissements de soins de longue durée, des services de santé communautaire et des programmes de santé publique dans la province. Elles offrent des services de santé dans la région et travaillent en collaboration avec les collectivités locales pour offrir des services de santé aux résidents locaux.

Les deux autorités sanitaires provinciales (l'*Alberta Cancer Board* et l'*Alberta Mental Health Board*) offrent des services de santé à l'échelle de la province.

Financement des autorités sanitaires régionales

Depuis l'exercice 1997-1998, l'Alberta a adopté une nouvelle méthode de financement des autorités sanitaires régionales afin que chaque région reçoive sa juste part de l'argent disponible pour le secteur de la santé. Cette méthode de financement correspond au financement en fonction de la population. Selon cette méthode, les fonds sont alloués à chaque autorité sanitaire régionale en fonction

de la population de chaque région et des dépenses prévues pour les soins de santé.

Les dépenses en santé pour une population donnée sont évaluées en prenant en considération les éléments suivants :

- la population totale pour chaque région;
- l'âge et le sexe de la population;
- la situation socio-économique de la population;
- les services offerts par les régions aux résidents des autres régions.

Financement des services offerts à l'échelle de la province

Le financement des services offerts à l'échelle de la province couvre une gamme de services de pointe, de services coûteux et de services de survie qui sont financés indépendamment des services de santé de base couverts par le financement octroyé en fonction de la population. Le ministère, l'autorité sanitaire de Calgary et l'autorité sanitaire de la capitale collaborent en vue de la planification et de la prestation des services offerts à l'échelle provinciale ainsi que de l'établissement de normes à leur égard. Ces services ne sont offerts qu'à Calgary et/ou à Edmonton. Ainsi, la disponibilité de services financés centralement pour tous les résidents de l'Alberta, peu importe leur lieu de résidence, est assurée.

Statistiques sur le régime d'assurance-santé de l'Alberta

Au cours de l'exercice 2000-2001, il y avait 4 856[1] médecins et 2 910[1] professionnels des domaines paramédicaux inscrits au régime d'assurance-santé de l'Alberta. Il y avait 3 007 582[1] résidents inscrits au même régime.

En 2000-2001, le régime d'assurance-santé de l'Alberta a émis l'équivalent de 959 073 855 $[1] en paiements à l'acte aux médecins de l'Alberta et un total de 57 804 028 $[1] aux professionnels des domaines paramédicaux (chirurgiens-dentistes/dentistes, chiropraticiens, optométristes, podologues) pour des services de santé de base.

Les principales activités de l'Alberta en 2000-2001 ont été les suivantes :

- proclamation de la *Health Care Protection Act* et de son règlement d'application le 28 septembre 2000;
- négociations et modifications de l'entente avec l'Association médicale de l'Alberta;
- poursuite de l'élaboration du guide de la valeur relative (*Relative Value Guide* - RVG);
- ajout de quatre nouveaux appareils d'imagerie par résonance magnétique (IRM) au système de santé - deux à Calgary et deux à Edmonton;
- introduction d'un projet-pilote pour couvrir les traitements dentaires spéciaux et coûteux pour les Albertains ayant une anomalie congénitale, un cancer ou un autre traumatisme nécessitant certains services orthodontiques requis avant que les services assurés de chirurgie buccale et maxillo-faciale puissent être offerts;
- programmes d'immunisation contre la méningite institués dans les régions à risque de la province;
- ouverture de huit postes de formation postdoctorale pour des diplômés internationaux en médecine à l'université de l'Alberta et à l'university de Calgary;
- le ministère a approuvé une nouvelle pharmacothérapie (thérapie photodynamique oculaire) pour la dégénérescence maculaire;
- en vigueur au 1er avril 2000, paiement accordé pour l'hébergement et les frais de subsistance (pour les personnes approuvées par le comité des services de santé à l'étranger conformément à l'article 26.1 de l'*Alberta Health Care Insurance Regulation*) en vue d'obtenir, à l'extérieur du Canada, des services assurés ou des services hospitaliers assurés en tant que patient en clinique externe.

[1] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

Parmi les grands défis qui devront être relevés par le ministère, notons :

- le coût des médicaments;
- la technologie et les changements démographiques;
- les attentes du public et les demandes de services;
- la viabilité des soins de santé en Alberta.

Le conseil consultatif sur la santé du premier ministre a été établi pour déterminer les stratégies essentielles pour soutenir un système de soins de santé efficace et de qualité pour la population de l'Alberta.

De plus amples renseignements sur le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta sont disponibles dans le site Web à www.health.gov.ab.ca.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le régime d'assurance-santé de l'Alberta (*Alberta Health Care Insurance Plan*), qui est sans but lucratif, est géré par le ministre de la Santé et du Mieux-être de l'Alberta.

Le régime d'assurance-santé de l'Alberta est administré en vertu de l'*Alberta Health Care Insurance Act* et de son règlement d'application. L'*Alberta Health Care Insurance Act*, promulguée en 1969, prévoit la prestation de services de santé de base pour tous les résidents de l'Alberta (aux termes de l'*Alberta Health Care Insurance Act*) et de services de santé complémentaires aux résidents albertains de 65 ans ou plus ou ceux qui reçoivent une pension de veuve et à leurs personnes à charge admissibles.

- Le fonctionnement du régime d'assurance-santé de l'Alberta est autorisé par l'article 3 (partie 1) de l'*Alberta Health Care Insurance Act*.
- L'article 4 décrit la protection offerte par le régime d'assurance-santé de l'Alberta.
- L'article 5 décrit le paiement des services assurés et les services d'urgence. Cet article interdit également la surfacturation et définit les autres frais qu'il est interdit de facturer aux patients.

Aucune modification législative n'a modifié le nom ou l'autorité publique du régime d'assurance-santé de l'Alberta en 2000-2001.

Le rôle et le mandat du ministère sont les suivants :

- préserver, protéger et améliorer la santé des Albertains et la qualité de leur système de santé;
- élaborer des politiques et des normes en matière de santé et déterminer les ressources nécessaires au maintien du système de santé et à la satisfaction continue des besoins en santé des Albertains;
- veiller à ce que les services de santé soient appropriés, bien gérés et accessibles à tous les Albertains.

1.2 Liens hiérarchiques

Le régime d'assurance-santé de l'Alberta est administré par la *Program Services Division* du ministère. Le sous-ministre adjoint de la division relève directement de la sous-ministre qui est elle-même sous les ordres du ministre de la Santé et du Mieux-être. Le ministre répond de sa gestion devant l'assemblée législative et le gouvernement albertain. En retour, le gouvernement de l'Alberta est responsable devant tous les Albertains.

Le ministère de la Santé et du Mieux-être publie un rapport annuel comprenant l'énoncé des responsabilités du ministère, la responsabilité de la direction de présenter un rapport et les états financiers consolidés du portefeuille ministériel de la Santé et du Mieux-être. En outre, le rapport annuel présente de l'information sur les mesures prises, les réalisations et les résultats des principales mesures de rendement comprises dans le plan des activités de l'exercice 2000-2001 pour chacun des quatre objectifs du ministère qui appuient les deux activités principales du ministère.

Les deux activités principales du ministère sont les suivantes :

- Diriger et appuyer un système pour la prestation de services de santé de qualité.
- Favoriser et appuyer un style de vie sain.

Le rapport annuel du ministère pour l'exercice prenant fin le 31 mars 2001 a été préparé sous la direction du ministre de la Santé et du Mieux-être de l'Alberta conformément à la *Government Accountability Act* et aux règles et méthodes comptables du gouvernement.

- La partie I du rapport annuel contient les états financiers consolidés et vérifiés du ministère et une comparaison du rendement actuel par rapport aux résultats prévus dans le plan des activités du ministère.
- La partie II présente les états financiers des autorités sanitaires régionales et des conseils provinciaux, qui ont l'obligation de rendre compte au ministre de la Santé et du Mieux-être de l'Alberta.

Chaque année, le ministère publie également un rapport statistique complémentaire qui comprend des données à jour relatives au régime d'assurance-santé de l'Alberta, essentiellement le nombre d'inscrits et les paiements à l'acte versés aux médecins et aux praticiens apparentés albertains (chirurgiens-stomatologistes, chirurgiens-dentistes, chiropraticiens, optométristes et podologues). Les statistiques concernant le programme de services de santé complémentaires et la protection individuelle de la Croix bleue de l'Alberta offerts dans le cadre du régime d'assurance-santé de l'Alberta sont également fournies.

1.3 Vérification des comptes

Les états financiers pour le régime d'assurance-santé de l'Alberta sont maintenant présentés avec les états financiers vérifiés du ministère de la Santé et du Mieux-être de l'Alberta. Les états financiers du portefeuille ministériel sont vérifiés par le vérificateur général de la province.

2.0 Intégralité

2.1 Services hospitaliers assurés

La *Hospitals Act* (Revised Statutes of Alberta 1980, chapitre H-11 avec les modications en vigueur le 1er décembre 1997), le *Hospitalization Benefits Regulation* (AR244/90), la *Health Care Protection Act* (promulguée le 28 septembre 2000) et le *Health Care Protection Regulation* sont les instruments juridiques qui prévoient la prestation des services assurés offerts dans les hôpitaux ou les établissements chirurgicaux désignés en Alberta.

Aucune modification n'a été apportée à la *Hospitals Act* ou au *Hospitalization Benefits Regulation* en 2000-2001.

Le ministre de la Santé et du Mieux-être de l'Alberta administre la *Hospitals Act*. Les autorités sanitaires régionales sont responsables de l'ensemble de l'administration et de la prestation de tous les services hospitaliers dans leur région. Conformément à la *Hospitals Act* et à son règlement d'application, les autorités sanitaires régionales doivent assurer la prestation des services désignés comme étant des « services hospitaliers assurés ». Les services offerts en plus des « services hospitaliers assurés » sont fournis à la discrétion de chaque autorité sanitaire régionale.

La *Hospitals Act* définit les services assurés comme les services hospitaliers dont les coûts opérationnels seront assumés en vertu de la présente partie et définit également l'hospitalisation en salle commune et l'endroit où les services assurés doivent être rendus. La nature de ces services est établie dans le *Hospitalization Benefits Regulation* (AR244/90).

Le *Hospitalization Benefits Regulation* définit les services assurés comme :

a) services aux malades hospitalisés

   i) l'hébergement en chambre semi-privée ou privée lorsque cette mesure se justifie pour des raisons médicales;

ii) les soins infirmiers privés, lorsque ceux-ci sont prescrits par le médecin traitant et approuvés conformément aux règlements de l'hôpital;

iii) les médicaments, les préparations biologiques et autres administrés à l'hôpital, aux termes des alinéas f) et g) du paragraphe 2;

iv) les stimulateurs cardiaques, les plaques en acier, les broches, les prothèses articulaires, les implants valvulaires et toute autre fourniture approuvée par le ministre;

v) le transport en Alberta, par ambulance ou au moyen de tout autre véhicule commercial pour les raisons décrites à l'article 6 [c'est-à-dire, le transport entre les hôpitaux];

vi) les produits et les services compris dans un programme hospitalier autorisé ou un programme particulier, mais qui ne sont pas inclus aux alinéas i) à v);

vii) les produits et services améliorés décrits au paragraphe 5.2(2) [doivent être médicalement nécessaires d'après le médecin traitant].

b) services aux malades externes – tous produits et services médicalement nécessaires pouvant être offerts en consultation externe, notamment les produits utilisés au cours d'un acte médical, excluant les produits donnés à un malade pour utilisation après son congé d'un hôpital ou d'un établissement autorisé.

Depuis le 12 avril 2000, des lentilles monofocales rigides ou pliables (implants) ont été fournies gratuitement à des patients comme partie intégrante du service hospitalier assuré lorsque fournies dans le cadre d'un service médical assuré.

Depuis le 28 septembre 2000, des plâtres et des plâtres en fibre de verre ont été fournis gratuitement à des patients comme partie intégrante du service hospitalier assuré lorsque fournis dans le cadre d'un service médical assuré.

En juin 2000, la couverture a été accordée pour la thérapie photodynamique oculaire parla Visudyne pour soigner la dégénérescence maculaire.

Le tableau 1 présente le nombre et les types d'établissement qui étaient en opération en Alberta au cours de l'exercice 2000-2001.[2]

Tableau 1 : Établissements de soins de santé par type*	
Établissements de soins actifs	102
(établissements qui offrent des services de santé qui sont fournis à des personnes souffrant soudainement de troubles de santé graves qui nécessitent des soins infirmiers professionnels continus et l'observation)	
Établissements de soins de longue durée	105
(établissements qui offrent des services de santé à des patients internes qui ont constamment besoin d'aide en raison d'une déficience chronique d'une durée minimale de plusieurs mois)	
Établissements de réadaptation	1
(établissements qui offrent des services de santé à des personnes ayant besoin d'aide professionnelle pour rétablir leurs capacités physiques et un état fonctionnel à la suite d'une maladie ou d'une blessure)	
Autres (établissements de soins communautaires)	3
Total	**211**

*exclut les hôpitaux psychiatriques et les maisons de repos

Les établissements chirurgicaux autres que les hôpitaux (établissements offrant des services de santé comprenant des interventions chirurgicales ne nécessitant pas un séjour de plus de 24 heures pour le réveil postopératoire ou observation – y compris des cliniques privées où se font des avortements, des chirurgies de la cataracte, ainsi que des cliniques dentaires et d'optométrie) et des établissements de diagnostic autres que des hôpitaux (établissements offrant des services de santé pour des interventions qui ne nécessitent pas un séjour de plus de 24 heures et qui permettent le dépistage et la détermination de diverses maladies ou divers troubles de santé) existent également dans la

[2] La partie du *Rapport annuel sur l'application de la Loi canadienne sur la santé de 1999-2000* portant sur l'Alberta ne traitait pas des établissements de soins de longue durée et de réadaptation. Cette année, en fonction des définitions des divers établissements (fournies par Santé Canada et convenues par les provinces et les territoires), nous avons modifié cette partie de l'exposé de manière à refléter les catégories d'établissements inscrites à l'annexe A du présent rapport (voir Statistiques sur les régimes d'assurance-santé provinciaux et territoriaux).

province. Ces établissements fonctionnent conformément à des ententes ou des contrats négociés avec les autorités sanitaires régionales. Le ministère de la Santé et du Mieux-être de l'Alberta recueille de l'information uniquement sur les services assurés qui sont payés à l'acte et offerts dans ces établissements et ne recueille pas de données sur les services hospitaliers assurés offerts dans ces établissements. Selon le *College of Physicians and Surgeons of Alberta*, il y a actuellement 52 établissements de chirurgie d'un jour de ce genre agréés conformément aux règlements du *College*. On y effectue des chirurgies d'un jour assurées et non assurées.

Il existe actuellement 36 contrats pour services chirurgicaux assurés avec 33 gestionnaires d'établissements. Le ministre a approuvé 34 des 36 contrats après la promulgation de la *Health Care Protection Act*. Les deux contrats existants qui prennent fin après la promulgation de la Loi ont été jugés comme approuvés. Toute modification à ces deux contrats ou leur renouvellement nécessite l'approbation ministérielle. Les types de services chirurgicaux assurés fournis par ces 36 établissements sont dans les domaines suivants : ophtalmologie, dermatologie, oto-rhino-laryngologie, stomatologie, orthopédie, interruption de grossesse et chirurgie plastique.

Des copies des 35 contrats avec l'autorité sanitaire de la capitale et l'autorité sanitaire de Calgary sont affichées sur leurs sites Web. Le contrat avec l'autorité sanitaire de Headwaters n'est pas affiché sur le site Web, mais il est possible d'obtenir une copie papier en communiquant avec leur bureau au (403) 601-8330. Des renseignements sur les contrats approuvés par le ministre sont affichés sur le site Web du ministère de la Santé et du Mieux-être de l'Alberta à l'adresse www.health.gov.ab.ca.

Le 28 septembre 2000, le gouvernement a promulgué la *Health Care Protection Act* et a adopté l'*Alberta Health Care Protection Regulation* qui définit le fonctionnement des établissements chirurgicaux agréés.

La *Health Care Protection Act* établit les règlements les plus rigoureux au pays pour protéger le système de santé financé par l'État en comblant les écarts des lois actuelles, en protégeant le système de soins de santé financé et administré par l'État, en empêchant la création d'un système à deux vitesses et en permettant aux autorités sanitaires d'améliorer l'accès aux services.

En vertu de cette loi :

- le fonctionnement des hôpitaux privés est interdit;
- les établissements chirurgicaux peuvent offrir des services chirurgicaux assurés s'ils ont négocié un contrat avec une autorité sanitaire et que cette dernière peut démontrer qu'il y a un avantage clair pour le système public;
- les frais d'établissement pour des services chirurgicaux assurés sont illégaux;
- il est illégal de contourner une liste d'attente pour les chirurgies assurées en payant ou en recevant de l'argent ou en achetant un service chirurgical non assuré ou un produit ou un service supérieur;
- les frais imputables pour des produits ou des services médicaux supplémentaires, qui ne sont pas médicalement nécessaires, ont été limités;
- les patients et le système de santé sont protégés contre les comportements contraires à l'éthique ou les situations de conflit d'intérêts.

En vertu de la *Health Care Protection Act*, les établissements chirurgicaux autres que les hôpitaux doivent respecter les conditions suivantes :

1. être agréés par le *College of Physicians and Surgeons* pour offrir des services chirurgicaux assurés;
2. avoir conclu une entente pour la prestation de ces services chirurgicaux assurés avec une autorité sanitaire et qui a été approuvée par le ministre;
3. être désigné par le ministre pour offrir ces services chirurgicaux assurés.

La Loi prévoit aussi les conditions qui doivent être respectées pour que le ministre approuve une entente entre une autorité sanitaire et un établissement chirurgical autres qu'un hôpital.

La prestation de services chirurgicaux assurés, telle que prévue en vertu de l'entente, est évaluée en fonction de facteurs tels que le respect de la *Loi canadienne sur la santé*, le besoin actuel et continu du service dans la région géographique, la possibilité de conséquences négatives sur le système de santé financé et administré par l'État en Alberta, les bienfaits prévus pour le public (meilleur accès, meilleure qualité, souplesse, efficacité accrue, amélioration de la rentabilité, etc.).

Lorsque le ministre approuve l'entente proposée entre l'autorité sanitaire et l'établissement chirurgical autre qu'un hôpital et est satisfait de l'agrément accordé à l'établissement pour la prestation de services chirurgicaux assurés, le ministre doit désigner l'établissement. La désignation comprend la description des services chirurgicaux assurés que l'établissement a le droit d'offrir, les conditions auxquelles est soumise la désignation et la publication ou la divulgation publique des motifs du ministre concernant la désignation d'un établissement ou la modification d'une désignation.

Le processus actuel pour établir le statut d'hôpital agréé (hôpitaux pour soins actifs et hôpitaux auxiliaires) comprend un examen du ministère et l'approbation du ministre. Pour un nouvel hôpital, le processus comprend une évaluation des besoins régionaux; l'établissement d'un programme et d'un plan de prestation de services; d'une étude de programme hospitalier fonctionnel; la détermination des centres fonctionnels; l'enregistrement des établissements et leur inclusion dans la liste ministérielle des hôpitaux autorisés *(Schedule of Approved Hospitals)*. La mise à jour du statut des hôpitaux autorisés qui comprend la modification ou l'intégration de la liste ministérielle *(Schedule of Approved Hospitals)* requiert la certification par la région sanitaire que les données autorisées concernant l'hôpital et les noms actuels sont exacts et que les hôpitaux autorisés sont gérés conformément aux lois et aux normes fédérales, provinciales et ministérielles pertinentes.

Les maisons de repos publiques sont gérées par les autorités sanitaires régionales qui ont également le mandat de négocier et d'autoriser des marchés relatifs au fonctionnement de maisons de repos privées ou sans but lucratif. Conformément à l'article 6 (partie 2) de la *Nursing Homes Act*, les autorités sanitaires régionales doivent fournir au ministre de la Santé et du Bien-être des exemplaires de tous les marchés conclus avec des maisons de repos.

Établissements de soins de longue durée en Alberta

Selon la loi en vigueur en Alberta, les établissements de soins de longue durée sont classés comme des maisons de repos ou des hôpitaux auxiliaires. L'ensemble de ces établissements est désigné comme des établissements de soins de longue durée.

Hôpital auxiliaire
En vertu de l'alinéa 1(1)c) de la *Hospitals Act*, hôpital auxiliaire désigne un hôpital pour le traitement de maladies de longue durée ou de maladies chroniques, de maladies ou des infirmités. Les hôpitaux auxiliaires sont la propriété des autorités sanitaires régionales ou d'organisations bénévoles sans but lucratif et sont gérés conformément à la *Hospitals Act* et à son règlement d'application.

Maison de repos
En vertu de l'alinéa 1m) de la *Nursing Homes Act*, une maison de repos correspond à un établissement où sont offerts des soins en maison de repos.

Les maisons de repos sont la propriété des autorités sanitaires régionales, d'organisations bénévoles ou privées et sont gérées conformément à la *Nursing Homes Act* et à son règlement d'application. Lorsqu'une maison de repos ou un hôpital auxiliaire est la propriété d'une organisation bénévole sans but lucratif ou privée, l'établissement est administré conformément à un contrat ou à une entente conclue avec l'autorité sanitaire régionale.

Les gestionnaires d'établissements de soins de longue durée ont la responsabilité de fournir tous les services requis en vertu de la *Nursing Homes Act* et son règlement et la *Hospitals Act* et son règlement.

Ces services comprennent :

- les services offerts par les hôpitaux auxiliaires et les maisons de repos, y compris les soins infirmiers professionnels et auxiliaires, les services d'une pharmacie, des services de nutrition, des services de physiothérapie et d'hébergement (par exemple, lessive, entretien ménager, entretien et administration);
- des services de comptes en fiducie;
- des fournitures pour des programmes de loisirs;
- des produits pharmaceutiques, des médicaments et les préparations connexes tels que prescrits par le médecin traitant, (y compris de l'oxygène);
- toutes les fournitures nécessaires pour les pansements et le traitement des plaies;
- les produits nécessaires pour les cas d'incontinence et le matériel associé aux soins liés à l'élimination urinaire;
- le transport, y compris le transport par ambulance, pour obtenir les soins prescrits;
- les suppléments alimentaires tels que prescrits par le médecin traitant;
- les meubles de base de la chambre;
- des items de soins spéciaux, tels que des mains courantes, des coussinets de peau de mouton, des coudières et des chevillères, des matelas réducteurs de pression, coussins pour côtés de lit, etc.

L'alinéa 25(1)h) de la *Health Care Protection Act* confère au lieutenant gouverneur en conseil le pouvoir d'établir si un bien ou un service médical quelconque est ou n'est pas un bien ou service standard ou amélioré. Le *Health Care Protection Regulation* établit les services chirurgicaux complexes, les interventions chirurgicales mineures et les biens et services standards ou améliorés. L'ajout ou le retrait d'un élément du *Health Care Protection Regulation* requiert la modification du règlement et les exigences du processus d'examen réglementaire du gouvernement doivent être respectées. Les décisions de routine concernant l'équipement et les fournitures utilisés dans le cadre d'une intervention sont du ressort des autorités sanitaires et des médecins et sont exclues de ce processus.

Le ministère procède à l'élaboration d'un processus pour définir les biens et les services standards et améliorés qui sera utilisé exceptionnellement pour examiner des biens ou des services médicaux qui ne peuvent être traités par une seule autorité sanitaire ou lorsqu'une incohérence est constatée dans les régions en ce qui concerne les prestations.

2.2 Services médicaux assurés

Le *Medical Benefits Regulation* régit les services couverts de même que les exigences relatives à la présentation, dans le cadre du régime d'assurance-santé de l'Alberta, de réclamations pour des actes médicaux. Le règlement fixe les tarifs d'après ceux établis dans le barème des prestations médicales assurées préparé et publié par le ministère de la Santé et du Mieux-être et approuvé par le ministre.

Aucune modification n'a été apportée à la loi ou au règlement pour l'exercice 2000-2001 relativement aux services médicaux assurés.

L'*Alberta Health Care Insurance Act* définit le terme « médecin » comme suit :

- en ce qui a trait aux services médicaux rendus en Alberta, personne inscrite en tant que médecin désigné ou ostéopathe désigné en vertu de la *Medical Profession Act*;
- en ce qui concerne les services médicaux fournis à l'extérieur de l'Alberta, personne autorisée par la loi à pratiquer la médecine ou l'ostéopathie à cet endroit.

L'*Alberta Health Care Insurance Act* définit le « praticien » comme suit :

- chiropraticien, mécanicien-dentiste, chirurgien-dentiste, opticien, optométriste, médecin, podologue ou toute autre personne qui fournit un service de santé de base ou un service de santé complémentaire.

La *Medical Profession Act* définit le « praticien inscrit » comme suit :

- personne inscrite au registre médical de l'Alberta ou inscrite temporairement en vertu de l'article 28.

Exigences concernant les médecins et les praticiens

Seuls ceux qui respectent les exigences ci-dessus peuvent offrir des services médicaux assurés en vertu du régime d'assurance-santé de l'Alberta.

Les cabinets de médecins doivent être inscrits par le ministère. Les médecins doivent recevoir les patients sur place, prendre les rendez-vous sur place et conserver les dossiers des malades sur place, pour que le ministère les inscrive.

Avant d'être inscrit auprès du ministère, un praticien doit remplir les formules d'inscription appropriées et fournir un exemplaire de son permis d'exercer (délivré par l'organisme ou l'association qui s'applique, c'est-à-dire, *College of Physician and Surgeons of Alberta, Alberta Dental Association, etc*).

Au 31 mars 2001, le nombre de médecins qui participaient au régime d'assurance-santé de l'Alberta se détaillait comme suit[3] :

Médecins	4 856
Dentistes/chirurgiens stomatologistes	1 484
Chiropraticiens	689
Optométristes	243
Podologues	44
Prothésistes dentaires	191
Opticiens	259
TOTAL	7 766

[3] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

Médecins qui ont opté pour le retrait du régime d'assurance-santé de l'Alberta

Conformément au paragraphe 5.11(1) de l'*Alberta Health Care Insurance Act*, tous les médecins sont considérés comme étant inscrits au régime d'assurance-santé de l'Alberta.

Un médecin peut traiter et facturer des patients pour des services indépendamment du régime d'assurance-santé de l'Alberta. Un médecin qui décide de se retirer du régime d'assurance-santé de l'Alberta doit respecter certaines conditions, au moins 180 jours avant la date d'entrée en vigueur du retrait. Ces conditions comprennent les points suivants :

- aviser le ministre, par écrit, de son intention de se retirer et indiquer la date d'entrée en vigueur du retrait;
- publier un avis du retrait proposé dans un journal à fort tirage de la région où ce dernier pratique;
- afficher un avis du retrait proposé dans un endroit du cabinet auquel les patients ont accès.

Au 31 mars 2001, un médecin de la province s'était retiré du régime d'assurance-santé de l'Alberta.

Barème des prestations médicales

Le *Medical Benefits Regulation* (AR 173/93) décrit les services assurés. Ces services figurent dans le barème des prestations médicales préparé et publié par le ministère et approuvé par le ministre. Plus particulièrement, ces services sont les suivants : services médicaux généraux; actes médicaux et de chirurgie généraux; anesthésie; médecine de laboratoire et pathologie; obstétrique; gynécologie; chirurgie cardio-thoracique et vasculaire; chirurgie générale; chirurgie orthopédique; neurochirurgie; chirurgie en urologie; oto-rhino-laryngologie; ophtalmologie; chirurgie plastique de reconstruction; médecine; psychiatrie; pédiatrie; dermatologie; physiothérapie et réadaptation; médecine d'urgence; radiologie de diagnostic; radiologie thérapeutique et neurologie. L'Alberta couvre également des services qui n'apparaissent pas sur cette liste mais qui sont considérés comme

médicalement nécessaires et qui ne relèvent pas de la recherche expérimentale ou appliquée.

Les services médicaux assurés et tous les changements subséquents (ajouts, retraits ou changements) apportés au barème des prestations médicales font l'objet de discussions entre le ministère de la Santé et du Mieux-être et l'Association médicale de l'Alberta (AMA), par l'entremise d'un sous-comité composé de membres du ministère et de l'AMA. Les changements apportés au barème nécessitent l'autorisation du ministre.

Au cours de la période allant du 1er avril 2000 au 31 mars 2001, les services suivants ont été ajoutés à la liste des services médicaux assurés dans le cadre du régime d'assurance-santé de l'Alberta :

- affectation par rotation – avantages pour temps libre;
- évaluation – avant une greffe du poumon;
- soins hospitaliers – après une greffe du poumon;
- dilatation par ballonnet d'un rétrécissement de la partie inférieure de l'appareil digestif (iléon ou colon) associée à une coloscopie;
- dilatation par ballonnet d'un rétrécissement de la partie inférieure de l'appareil digestif (iléon ou colon) associée à une sigmoïdoscopie;
- dilatation par ballonnet d'un rétrécissement de la partie supérieure de l'appareil digestif (estomac, duodénum ou jéjunum);
- retrait d'une sonde double J;
- gestion d'une dystocie fœtale;
- réduction fœtale sélective;
- reconstruction du ligament latéral et/ou de la plaque palmaire de l'articulation métatarso-phalangienne ou de l'articulation interphalangienne;
- injection(s) des zones gâchettes intravaginales;
- à compter du 1er juin 2000, des services de consultation peuvent être couverts pour un médecin lorsqu'une sage-femme recommande une patiente pour consultation;
- le temps du traitement à l'oxygène hyperbare – plus de 15 minutes;
- débridement des antres mastoïdiens et/ou réparation d'une petite perforation – sous microscopie;
- application d'un plâtre de fibre de verre, membre inférieur;
- application d'un plâtre de fibre de verre, membre supérieur, à l'exception d'un doigt;
- greffe osseuse de la crête iliaque suivant le prélèvement de tissus osseux pour chirurgie neurospinale;
- consultations psychiatriques prolongées – par tranche de 15 minutes supplémentaires – lorsque la consultation est de plus de 60 minutes;
- évaluation d'un trouble non lié dans le cas d'un service offert dans le contexte d'un accident de travail;
- deuxième participation d'un médecin et présence subséquente à une entrevue ou à une conférence de cas prévue et officielle au nom d'un patient particulier âgé de 18 ans ou moins – par 15 minutes;
- embolectomie ou endartériectomie périphérique (Nota : ne peut être réclamé qu'en relation avec une autre chirurgie vasculaire par l'entremise de la même artériotomie);
- ultrason endoscopique de lésions œsophagiennes ou gastriques;
- ultrason endoscopique de lésions rectales.

2.3 Services de chirurgie dentaire assurés

En vertu du régime d'assurance-santé de l'Alberta, l'Alberta couvre un certain nombre de chirurgies dentaires médicalement nécessaires, énumérées dans le barème des prestations de chirurgie buccale et maxillo-faciale. Un dentiste ou un chirurgien-dentiste peut pratiquer un petit nombre de ces interventions, mais la majeure partie des interventions ne peuvent être facturées au régime d'assurance-santé de l'Alberta que si elles sont pratiquées par un chirurgien stomatologiste ou un spécialiste en chirurgie maxillo-faciale.

Les dentistes (ou les chirurgiens-dentistes) doivent faire partie de l'*Alberta Dental Association* ou doivent avoir le droit de pratiquer la chirurgie dentaire n'importe où à l'extérieur de l'Alberta. Les chirurgiens stomatologistes et les spécialistes en chirurgie maxillo-faciale doivent être spécialisés dans la chirurgie buccale et maxillo-faciale, être membres de l'*Alberta Dental Association* ou avoir le droit de pratiquer la chirurgie buccale et maxillo-faciale n'importe où à l'extérieur de l'Alberta.

Au 31 mars 2001, 1 484[4] chirurgiens stomatologistes ou dentistes participaient au régime d'assurance-santé de l'Alberta (c'est-à-dire, offrant des services en vertu du programme de services de santé complémentaires pour les aînés et le programme de services de chirurgie dentaire assurés). Toutefois, au cours de l'exercice 2000-2001, seulement 232[4] chirurgiens stomatologistes ou dentistes ont facturé des chirurgies dentaires assurées au régime d'assurance-santé de l'Alberta.

Les dispositions concernant la participation au régime d'assurance-santé de l'Alberta des dentistes et leur retrait sont établies dans le paragraphe 5.1(1) de l'*Alberta Health Care Insurance Act*. Conformément à ce paragraphe, tous les dentistes sont considérés comme étant inscrits au régime d'assurance-santé de l'Alberta.

Un dentiste peut traiter et facturer des patients pour des services indépendamment du régime d'assurance-santé de l'Alberta. Un dentiste qui veut se retirer du régime d'assurance-santé de l'Alberta doit respecter certaines conditions, au moins 180 jours avant la date d'entrée en vigueur du retrait. Ces conditions comprennent les activités suivantes :

- aviser le ministre, par écrit, de son intention de se retirer et indiquer la date d'entrée en vigueur du retrait;
- publier un avis du retrait proposé dans un journal à fort tirage de la région où ce dernier pratique;
- afficher un avis du retrait proposé dans un endroit du cabinet auquel les patients ont accès.

Au 31 mars 2001, aucun chirurgien stomatologiste ou dentiste de la province ne s'était retiré du régime d'assurance-santé de l'Alberta.

En vertu du régime d'assurance-santé de l'Alberta, les interventions suivantes sont assurées et figurent dans l'*Oral and Facial Surgery Benefits Regulation*. [Nota – Les décisions à savoir a) si les interventions sont médicalement nécessaires et b) l'endroit où elles doivent être pratiquées sont laissées à la discrétion du chirurgien et sont fonction des besoins médicaux du patient] :

- entrevue, évaluation ou consultation diagnostique; arthroscopie de l'articulation temporo-maxillaire;
- injection ou infusion d'autres substances thérapeutiques ou prophylactiques; cranioplastie;
- chirurgie des nerfs périphériques crâniens;
- résection sous-muqueuse de la cloison nasale;
- réduction chirurgicale d'une fracture nasale; antrotomie intranasale;
- chirurgie plastique réparatrice du sinus de la face;
- excision d'une lésion dentale de la mâchoire; autres interventions en orthodontie;
- chirurgie plastique réparatrice de la langue;
- autres interventions de la langue; ablation de la glande ou du canal salivaire;
- excision d'une lésion de la glande salivaire;
- autres chirurgies de la glande ou du canal salivaire;
- drainage de la face ou du plancher de la bouche;
- incision du palais;
- excision d'une lésion ou du tissu du palais; chirurgie plastique de la bouche (interne); palatoplastie; technique diagnostique effractive sur la cavité buccale; autres chirurgie de la bouche et du visage;

[4] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

- chirurgie plastique du pharynx;
- contrôle d'une hémorragie (non précisée);
- réduction de fractures du visage;
- incision du massif facial sans division;
- arthroplastie temporo-mandibulaire;
- autres chirurgies plastiques du massif facial et ostéoplastie;
- technique diagnostique effractive du massif facial;
- autres chirurgies des os et des articulations du visage;
- séquestrectomie; synovectomie;
- chirurgie plastique réparatrice des structures des articulations;
- incision des muscles, des tendons, du fascia et des bourses;
- relaxation des cicatrices ou de la contracture cutanée;
- greffe du pédicule ou du lambeau;
- fournitures buccales ou destinées aux brûlés.

La *Claims Branch* de la *Program Services Division* du ministère gère tout ajout de nouveaux services de chirurgie dentaire à la liste des services assurés. Les changements apportés au barème nécessitent une autorisation ministérielle. Tous les changements (ajout ou retrait de services) sont apportés par l'entremise d'une vaste consultation du ministère, de l'*Alberta Dental Association* et de la section des chirurgies buccales et maxillo-faciales de l'*Alberta Dental Association* et sont soutenus par des études d'évaluation de leur incidence. Selon les changements apportés, les autorités sanitaires régionales peuvent être également consultées.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Le paragraphe 4(2) du *Hospitalization Benefits Regulation* contient une liste des services hospitaliers non assurés. Ce règlement fait partie des Documents supplémentaires soumis à Santé Canada (voir la fin de cet exposé). Les services requis pour des tiers, les services couverts en vertu d'une autre loi provinciale, territoriale ou fédérale, les services qui ont été jugés non essentiels pour le patient (c'est-à-dire, bien ou service amélioré), les services de laboratoire et de radiographie, les médicaments, les produits biologiques et les préparations connexes (dans certains cas) ainsi que les services fournis par un établissement à l'extérieur du Canada sans autorisation préalable du ministre, sont des genres de services non assurés inscrits dans le *Hospitalization Benefits Regulations*.

La *Health Care Protection Act* (article 5) et le *Health Care Protection Regulation* précisent les conditions qui s'appliquent lorsque les patients sont facturés pour les biens ou des services médicaux améliorés liés à la prestation d'un service chirurgical assuré. Ces dispositions de la loi s'appliquent aux hôpitaux publics et aux établissements chirurgicaux autres que les hôpitaux. La loi limite la facturation aux biens et aux services médicaux améliorés inscrits à la liste de l'annexe 2 du règlement. Actuellement, il n'y a qu'un bien médical amélioré : les lentilles intraoculaires multifocales (implants). Il prévoit aussi la méthode pour déterminer le montant qui peut être facturé pour un bien ou un service médical amélioré. En outre, la loi comprend des dispositions concernant l'obligation d'informer le patient lorsqu'un bien ou un service amélioré est offert, c'est-à-dire que les patients doivent être informés que le bien ou le service médical de base respecte les normes de pratique médicale reconnues et qu'il est disponible gratuitement. Voici donc seulement quelques-unes des dispositions clés concernant la vente de biens et de services.

L'article 21 du *Alberta Health Care Insurance Regulation* indique quels services ne sont pas des services de santé de base ou des services de santé élargis et ne sont donc pas considérés comme des services assurés. Ce règlement fait partie des Documents supplémentaires soumis à Santé Canada (voir la fin de cet exposé). Brièvement, voici certains services qui ne sont pas considérés comme des services assurés en vertu du règlement : les services offerts pour des tiers (compagnies d'assurance, services médicolégaux, etc.); les conseils donnés par téléphone ou par l'entremise d'un autre moyen de télécommunication (comprend les redevances pour celui-ci); les frais de transport

(comprend les coûts pour les patients et les médecins ainsi que les frais d'ambulance, à moins que le ministre en décide autrement); les services couverts par une autre loi provinciale, territoriale ou fédérale; les immunisations de groupe; les services offerts par un médecin à ses enfants, à ses frères et sœurs, à ses parents ou à son conjoint, à moins que le ministre en décide autrement.

Le barème de prestations de chirurgie buccale et maxillo-faciale présente les services qui ne sont pas assurés en vertu de ce barème. Ce barème fait partie des Documents supplémentaires soumis à Santé Canada (voir *Schedule of Oral and Maxillofacial Surgery Benefits, 2001*, à la fin de cet exposé). Parmi les services non assurés, notons les services de nature cosmétique, les produits pharmaceutiques et les médicaments, les conseils donnés par téléphone, les services ambulanciers, les services non requis médicalement, le temps de déplacement et les services offerts par un médecin à ses enfants, à ses frères et sœurs, à ses parents ou à son conjoint, à moins que le ministre en décide autrement.

Responsabilités des autorités sanitaires régionales

L'article 5 (dispositions concernant les responsabilités des autorités sanitaires régionales) de la *Regional Health Authorities Act* se détaille comme suit. Sous réserve de la loi et de son règlement, une autorité sanitaire régionale doit : i) promouvoir et protéger la santé de la population de la région sanitaire et œuvrer pour la prévention des maladies et des blessures; ii) évaluer continuellement les besoins en matière de santé des régions sanitaires; iii) établir les priorités de la prestation des services de santé dans la région sanitaire et affecter les ressources en conséquence; iv) veiller à ce qu'on ait un accès raisonnable à des services de santé de qualité partout dans la région sanitaire; v) promouvoir des services de santé qui répondent aux besoins des personnes et des collectivités et qui soutiennent l'intégration des services et des établissements de la région sanitaire. Les autorités sanitaires régionales veillent à ce que les décisions relatives à l'accès aux services hospitaliers et autres services de santé communautaire assurés soient fondées sur les besoins.

Facturation non associée au régime d'assurance-santé de l'Alberta

En vertu du paragraphe 31.1(1) de l'*Alberta Health Care Insurance Regulation*, personne ne peut demander des frais : a) dont le paiement est essentiel à la prestation d'un service assuré fourni par un médecin ou par un chirurgien-dentiste qui participe au régime d'assurance-santé de l'Alberta; b) qui s'ajoutent au montant versé par le ministre pour assumer les coûts du service assuré.

Conformément à la *Loi canadienne sur la santé*, le régime d'assurance-santé de l'Alberta couvre les services médicalement nécessaires que les médecins donnent aux patients. Lorsqu'un service n'est pas médicalement nécessaire, les médecins peuvent facturer un patient pour ce service. Le ministère ne réglemente pas la facturation de services non assurés par les médecins. Le *College of Physicians and Surgeons of Alberta* a élaboré et applique une politique sur cette question intitulée *Charging for Uninsured Services*, et l'Association médicale de l'Alberta fournit aux médecins un document intitulé *Guide to Direct Billing for Uninsured Services*.

L'entente entre le ministère de la Santé et du Mieux-être de l'Alberta et l'Association médicale de l'Alberta définit le terme désassurer de la façon suivante : en ce qui concerne un service assuré, la décision du ministre qu'un tel service assuré ne soit plus un service assuré et ne soit plus remboursable en vertu du régime. Selon cette entente, le ministère de la Santé et du Mieux-être de l'Alberta doit aviser l'Association médicale de l'Alberta de toute proposition concernant le fait de désassurer un service et la proposition doit faire l'objet d'une discussion du Comité des finances, un organisme mixte du ministère de la Santé et du Mieux-être de l'Alberta et de l'Association médicale de l'Alberta qui administre l'entente. Si l'Association médicale de l'Alberta n'est pas d'accord avec la proposition de désassurer le service, le ministère de la Santé et du Mieux-être de l'Alberta doit attendre trois mois à partir de la date de notification pour retirer le service du barème des prestations médicales.

Avant de désassurer (supprimer) des services inscrits au barème des prestations de chirurgie buccale et maxillo-faciale, le ministère de la Santé et du Mieux-être de l'Alberta doit consulter l'*Alberta Dental Association*.

En examinant si de nouveaux produits, services ou appareils médicaux devraient être couverts par l'État, le processus du ministère comprend d'abord un examen de la documentation scientifique et la recherche de conseils de spécialistes concernant la sécurité et l'efficacité du produit et, ensuite, de prévoir la diffusion d'une politique, l'octroi d'un financement, la formation et les autres conséquences associées à la couverture publique. Les questions nécessitant un traitement immédiat sont considérées selon un processus de gestion des dossiers et la direction générale jugée la plus adéquate est saisie de la question.

3.0 Universalité

3.1 Admissibilité au régime

Les paragraphes 3(1) et 4(3) de l'*Alberta Health Care Insurance Act* de même que les paragraphes 4(1) et 4(2) et les articles 4.1 et 4.2 de l'*Alberta Health Care Insurance Regulation*, l'article 18.2 de la *Health Insurance Premiums Act* et l'article 21 du *Health Insurance Premiums Regulation* définissent l'admissibilité au régime d'assurance-santé de l'Alberta.

Les résidents de l'Alberta sont admissibles à la prestation des services couverts par le régime d'assurance-santé de l'Alberta. Le mot « résident » s'entend d'une personne légalement autorisée à être ou à résider au Canada, domiciliée et résidant habituellement en Alberta et de toute autre personne considérée comme telle dans le cadre du règlement, à l'exception d'une personne faisant du tourisme ou qui est de passage ou en visite dans la province.

Les personnes de l'extérieur du Canada qui déménagent en Alberta pour y établir leur résidence permanente sont admissibles à la couverture si elles sont des résidentes permanentes, des résidentes permanentes de retour au pays ou, encore, des Canadiennes de retour au pays. Tous les nouveaux résidents permanents doivent présenter un exemplaire de leur fiche d'établissement. Les résidents temporaires de l'extérieur du Canada, qui peuvent être considérés comme des résidents, comprennent les personnes dont le nom figure sur les fiches des visiteurs et celles qui détiennent un permis de séjour pour étudiant, un permis de travail ou un permis ministériel.

Dans chacun de ces cas, des exemplaires des documents d'entrée au Canada doivent faire l'objet d'un examen avant que la personne puisse participer au régime d'assurance-santé de l'Alberta. Une personne doit avoir reçu l'autorisation de séjourner au Canada pendant au moins 12 mois consécutifs et qu'elle ait l'intention de demeurer tout ce temps en Alberta pour être admissible.

Les demandeurs du statut de réfugié arrivés au Canada avant le 1er janvier 1989 qui prévoient résider en Alberta pendant 12 mois peuvent également participer au régime d'assurance-santé de l'Alberta. Les demandeurs du statut de réfugié arrivés au Canada après le 1er janvier 1989 ne sont pas admissibles tant qu'ils n'ont pas obtenu le statut de réfugié au sens de la Convention.

Les personnes de l'extérieur du Canada qui déménagent en Alberta pour y établir leur résidence permanente sont admissibles à la couverture à partir de leur date d'arrivée, à condition que tous leurs documents d'entrée au Canada soient conformes et qu'elles s'inscrivent dans les trois mois suivant leur arrivée. Les personnes en provenance d'une autre région du Canada qui déménagent de façon permanente en Alberta sont admissibles à une protection à partir du premier jour du troisième mois suivant leur arrivée, à condition qu'elles s'inscrivent dans les trois mois suivant leur arrivée.

Aucune modification n'a été apportée à la loi ou au règlement pour l'exercice 2000-2001.

Les résidents non admissibles à la protection dans le cadre du régime d'assurance-santé de l'Alberta sont les suivants :

- les membres des Forces canadiennes;

- les membres gradés de la Gendarmerie royale du Canada (GRC);
- les détenus des pénitenciers fédéraux.

Toutefois, les membres de leurs familles sont admissibles à la couverture.

Les résidents de l'Alberta qui n'appartiennent plus aux Forces canadiennes ou à la GRC sont admissibles à la couverture. De plus, les détenus des pénitenciers fédéraux qui sont libérés en Alberta sont admissibles à la couverture le jour de leur libération.

3.2 Exigences relatives à l'inscription au régime

Tous les nouveaux résidents albertains, à l'exception de ceux qui font l'objet d'une exemption particulière, doivent s'inscrire et inscrire les personnes à leur charge admissibles au régime d'assurance-santé de l'Alberta en remplissant une demande dans les trois mois suivant leur arrivée. Si la demande n'est pas reçue dans les délais prescrits, la date d'entrée en vigueur de la protection est déterminée au moment de l'inscription. Suivant l'inscription, le titulaire du compte et les personnes à sa charge, le cas échéant, reçoivent chacun un numéro de santé personnel et une carte qui permettent d'obtenir des services de santé.

Pour les besoins de la facturation, les membres de la famille sont inscrits au même compte pour s'assurer que les services (par exemple, services de santé complémentaires, couverture individuelle de la Croix bleue) puissent être dispensés à tous les membres de la famille.

Dans la plupart des cas, la définition des personnes à charge inclut l'époux, l'épouse et les enfants de moins de 21 ans qui sont célibataires et totalement à la charge de leurs parents. S'entend également des personnes à charge :

- les enfants adoptés, les enfants en famille d'accueil et les pupilles pour lesquels le résident a droit à une déduction fiscale;
- les enfants célibataires de plus de 21 ans qui sont entièrement à la charge de leurs parents en raison d'un handicap physique ou mental;
- les enfants célibataires de moins de 25 ans qui étudient à plein temps dans un établissement d'enseignement reconnu;
- les conjoints séparés ou les conjoints de fait (qui peuvent choisir de payer leurs primes séparément).

Au 31 mars 2001, le nombre de résidents inscrits au régime d'assurance-santé de l'Alberta était de 3 007 582[5].

Les résidents qui décident de ne pas participer au régime d'assurance-santé de l'Alberta peuvent s'en retirer à chaque début de période de prestation. Une période de prestation commence le 1er juillet d'une année et se termine le 30 juin de l'année suivante. Une déclaration de retrait doit être remplie avant le 30 juin de chaque année. Par ailleurs, les primes doivent être entièrement payée au 30 juin de l'année en cours. Les nouveaux titulaires de compte peuvent se retirer au moment de l'inscription ou de la réintégration. La période de retrait commence le jour où la protection serait entrée en vigueur. Pour ne pas participer au régime d'assurance-santé de l'Alberta, les résidents doivent remplir une déclaration de retrait au plus tard le 30 juin de chaque année.

Pour la période du 1er juillet 2000 au 30 juin 2001, 233 personnes s'étaient retirées du régime d'assurance-santé de l'Alberta.

3.3 Autres catégories de personnes

Les résidents temporaires arrivant de l'étranger qui peuvent être considérés comme des résidents comprennent les personnes dont le nom figure sur les fiches des visiteurs et celles qui détiennent un permis de séjour pour étudiant, un permis de travail ou un permis ministériel. Dans tous ces cas, la personne doit

[5] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

faire examiner ses documents d'entrée au Canada avant que son admissibilité ne soit établie. Une personne doit avoir un permis de séjour au Canada pour au moins 12 mois et prévoir demeurer en Alberta pendant ce temps. Les demandeurs du statut de réfugié arrivés au Canada avant le 1er janvier 1989 qui prévoient résider en Alberta pendant 12 mois peuvent également participer au régime d'assurance-santé de l'Alberta. Les demandeurs du statut de réfugié arrivés au Canada après le 1er janvier 1989 ne sont pas admissibles tant qu'ils n'ont pas obtenu le statut de réfugié au sens de la Convention.

Les chiffres suivants indiquent le nombre estimé de personnes résidant en Alberta qui, au 31 mars 2001, sont couvertes en vertu des conditions susmentionnées :

Permis ministériels	158
Permis de séjour pour étudiant	5 038
Fiches du visiteur	3 058
Permis de travail	5 110

3.4 Primes

Tous les habitants de l'Alberta (à l'exception des personnes à charge et de celles qui n'ont pas le droit de s'inscrire) doivent payer des primes. Les personnes inscrites dans des groupes spéciaux, tels que les personnes qui reçoivent une pension de veuve en Alberta ou un soutien à l'autonomie, n'ont pas à payer les primes. Les primes mensuelles s'élèvent actuellement à 34 dollars par personne et à 68 dollars par famille (deux personnes ou plus). Deux programmes offrent une aide aux Albertains à faible revenu (autres que des aînés) à payer leurs primes : le programme de subvention et le programme d'exonération totale des primes. Les aînés doivent payer les mêmes primes que les autres habitants. L'admissibilité des aînés à l'aide au paiement des primes est déterminée par l'entremise du programme de services assurés pour les aînés de l'Alberta.

Bien que le système en vigueur en Alberta prévoie le versement de primes, aucun habitant de la province ne se voit refuser les services en raison de son incapacité à payer ces primes.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes en provenance d'une autre région du Canada qui s'installent en Alberta de façon permanente peuvent participer au régime d'assurance-santé de l'Alberta à partir du premier jour du troisième mois suivant leur arrivée, pourvu qu'ils s'inscrivent au cours de ces trois premiers mois.

4.2 Couverture durant des absences temporaires (au Canada)

Les paragraphes 5(1) et 5(3) de l'*Alberta Health Care Insurance Act* et le paragraphe 1(2) de l'*Alberta Health Care Insurance Regulation* définissent la transférabilité de l'assurance-santé durant les absences temporaires au Canada.

Les résidents quittant temporairement l'Alberta pour une autre région du Canada pour un période maximale de 12 mois doivent conserver la couverture du régime d'assurance-santé de l'Alberta pendant leur absence. Si l'absence sera de plus de 12 mois, la couverture peut être annulée ou les résidents peuvent se prévaloir de l'option permettant la demande d'extension. Ces extensions sont pour :

- des séjours prolongés ou des vacances – une période maximale de 24 mois à partir de la date de départ. La demande d'extension doit être présentée en personne, par téléphone ou par écrit.
- un emploi ou des obligations d'affaires – une période maximale de 48 mois consécutifs suivant leur date de départ. Une lettre de l'employeur confirmant la durée du contrat de travail est requise.
- des études à temps plein – les étudiants inscrits à temps plein à un établissement d'enseignement reconnu sont admissibles à

une couverture jusqu'à ce que leur formation soit terminée. Après la première année, le statut d'étudiant doit être vérifié chaque année pour maintenir la couverture.

- les congés sabbatiques et les congés de travail pour l'obtention d'une formation avancée - une période maximale de 24 mois consécutifs suivant leur date de départ. Une lettre de l'employeur confirmant la tenue de la formation et la durée de l'absence est requise.
- les missionnaires pour un organisme religieux enregistré et autorisé – une période maximale de 48 mois consécutifs suivant leur date de départ. La personne doit présenter une lettre de l'organisme religieux confirmant la date de départ, sa destination et la durée de l'absence. Les missionnaires peuvent revenir en Alberta pendant un congé (congé autorisé ou vacances). La période pendant laquelle ils sont en Alberta fait partie de leur période d'absence temporaire et n'indique pas qu'ils se sont de nouveau établis de façon permanente en Alberta.

Entente de réciprocité des hôpitaux

À compter du 15 novembre 2000, l'*Alberta Health Care Insurance Regulation* a été modifié de manière à définir les absences temporaires comme celles qui n'excèdent pas six mois à l'extérieur du Canada ou 12 mois au Canada; à éliminer la disposition rendant la couverture obligatoire pour les 12 premiers mois, même si l'absence est pour plus de 12 mois; et éliminer les motifs des absences et les échéanciers afin qu'ils puissent être établis en vertu d'une politique. Ceci sera mieux adapté pour ceux qui veulent maintenir leur couverture pendant des périodes d'absence temporaire plus longues ainsi que ceux qui veulent annuler leur couverture pendant une absence prolongée.

Entente de réciprocité des services médicaux

L'Alberta participe à des ententes de réciprocité des hôpitaux conclues avec les provinces et les territoires, qui permettent le traitement des coûts des services hospitaliers fournis à des Albertains et à des personnes de l'extérieur par la province ou le territoire d'accueil. Les réclamations sont payées d'après le tarif standard pour la prestation de services aux malades hospitalisés en salle commune approuvé par chaque province ou territoire et d'après les tarifs pour la prestation de services externes approuvés par le Comité de coordination de la facturation réciproque. Les données sur les réclamations sont échangées une fois par mois avec chaque province ou territoire.

L'Alberta participe à des ententes de facturation réciproque des services médicaux conclues avec les provinces et les territoires (sauf le Québec). Ces ententes permettent le traitement des coûts des services médicaux fournis à des Albertains et à des personnes de l'extérieur par la province d'accueil. Les réclamations sont payées d'après les tarifs et les règlements du barème des honoraires du médecin de la province ou du territoire d'accueil pour les services médicaux assurés. Les données sur les réclamations sont échangées une fois par mois avec chaque province ou territoire.

Dans le cas de certains services exclus du processus de facturation réciproque, comme les avortements, le médecin doit faire parvenir sa facture directement à la province ou au territoire de résidence du patient, qui l'étudiera pour les besoins du paiement.

L'autorité sanitaire de la capitale a également conclu une entente avec les Territoires du Nord-Ouest qui permet aux malades de ce territoire de recevoir des traitements dans les hôpitaux de la région, lesquels seront payés à un tarif convenu pour les services rendus aux malades hospitalisés. Le processus de facturation pour ces réclamations ressemble à celui prévu dans le cadre d'une entente de facturation réciproque des hôpitaux conclue entre les provinces et les territoires concernant les services fournis aux malades hospitalisés. Les services exclus de la facturation réciproque le sont également de cette entente bilatérale conclue avec les Territoires du Nord-Ouest.

Le paiement des services hospitaliers et médicaux assurés dispensés ailleurs au Canada aux Albertains admissibles est effectué selon le tarif approuvé par le régime d'assurance-hospitalisation de la province ou du territoire d'accueil, à moins que le ministre ait conclu une entente avec le gouvernement

d'une province ou d'un territoire relativement à une répartition différente des coûts.

Le paiement des services médicaux assurés qui sont dispensés ailleurs au Canada aux Albertains admissibles est effectué au tarif de la province ou du territoire d'accueil, le Québec y compris.

En 2000-2001, le montant total versé pour des services hospitaliers fournis aux malades hospitalisés et aux malades externes à l'extérieur de la province (au Canada) s'élevait à 19 602 875 $[6].

4.3 Couverture durant des absences temporaires (à l'étranger)

Les paragraphes 5(1) et 5(3) de l'*Alberta Health Care Insurance Act* et le paragraphe 1(2) de l'*Alberta Health Care Insurance Regulation* définissent la transférabilité de l'assurance-santé durant les absences temporaires à l'extérieur du Canada.

Les résidents de l'Alberta qui quittent le Canada pour six mois ou moins doivent maintenir leur couverture en vertu du régime d'assurance-santé de l'Alberta au cours de leur absence. Si l'absence est pour une période de plus de six mois, la couverture peut être annulée ou les résidents peuvent demander une extension. Ces extensions sont les mêmes que pour les absences temporaires au Canada (voir les détails à la partie 4.2 pour une description des extensions).

Pour une description des modifications apportées à la loi ou au règlement en 2000-2001 concernant la transférabilité à l'étranger, prière de consulter le paragraphe 3 de l'article 4.2. Au 15 novembre 2000, des modifications ont été apportées à l'*Alberta Health Care Insurance Regulation* qui touchaient les absences temporaires au Canada et à l'étranger.

Les prestations d'hospitalisation ne sont payables que si les services sont fournis par des établissements de soins actifs qui dispensent des services courants, comme l'unité des soins intensifs ou la salle d'urgence, ou des hôpitaux auxiliaires qui dispensent des soins actifs courants à des malades chroniques ou à des malades nécessitant des soins de longue durée. Si les services ne sont pas assurés dans la province, ils ne le sont pas non plus quand ils sont fournis à l'étranger. Le montant maximum payable pour les services dispensés aux patients hospitalisés à l'étranger est de 100 dollars canadiens par jour (à l'exclusion du jour où le congé est accordé). Le coût maximum par visite pour les patients externes est de 50 dollars canadiens. Certains services spécialisés de consultation externe, notamment la tomodensitométrie, sont payés selon un barème plus élevé.

Les prestations pour les services médicaux fournis à l'étranger sont payables selon les tarifs facturés ou les tarifs en vigueur en Alberta, suivant celle de ces deux sommes qui est la moindre.

Le remboursement complet des traitements à l'extérieur du pays peut être possible dans le cadre des deux programmes suivants :

1. le programme de services de santé fournis à l'étranger, qui peut s'appliquer aux services qui ne sont pas offerts au Canada;
2. le programme d'aide financière d'urgence, qui peut s'appliquer aux frais pour les traitements imprévus.

4.4 Nécessité d'une approbation préalable

Il faut obtenir une autorisation préalable du ministre pour les services facultatifs fournis à l'extérieur de l'Alberta dans le cadre du traitement de l'alcoolisme et de la toxicomanie, des troubles alimentaires et d'autres troubles de comportement liés à une dépendance, que ces soins soient fournis à l'extérieur de la province ou à l'extérieur du pays.

[6] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

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Les demandes d'autorisation préalable pour hospitalisation et traitement médical à l'extérieur de l'Alberta (à l'intérieur du Canada) doivent être soumises au ministère par le médecin responsable du traitement du patient en Alberta ou par le médecin de l'administration provinciale pertinente. Les demandes d'autorisation préalable pour des services de santé à l'extérieur du pays sont soumises au *Out-of-Country Health Services Committee* par le médecin traitant de l'Alberta ou le patient.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

L'accès des résidents de l'Alberta aux services de santé assurés est régi selon des modalités uniformes, sans restrictions.

Aucun habitant ne se voit refuser les services de santé assurés en raison de son incapacité à payer les primes, et les inscriptions ne sont pas annulées en raison du non-paiement des comptes. De même, deux programmes offrent une aide aux Albertains à faible revenu à payer leurs primes.

Ces programmes sont :

- le programme de subvention des primes;
- le programme d'exonération totale des primes.

Depuis 1986, la « surfacturation » par les médecins et les « frais modérateurs » exigés aux patients pour les services assurés sont interdits.

La politique albertaine permet aux praticiens de présenter des réclamations pour des services fournis à des patients qui n'étaient pas en mesure de donner un numéro de santé de l'Alberta au moment où ils recevaient le service. Le patient ne peut se prévaloir qu'une seule fois de cette disposition et le praticien doit d'abord s'assurer que le malade réside en Alberta.

5.2 Accès aux services hospitaliers assurés

Depuis 1994, la prestation de services hospitaliers en Alberta relève des autorités sanitaires régionales.

En février 2000, le gouvernement a annoncé l'adoption de son plan d'activités de 2000-2001 à 2001-2003 prévoyant un financement accru du système de santé provincial.

En vertu de ce plan d'activités, les dépenses du système de santé albertain ont augmenté de 482 millions de dollars, une hausse de 9,3 pour cent comparativement au budget de base de 1999-2000.

Ces dépenses accrues ont permis l'amélioration de l'accès aux services financés par l'État et aux autorités sanitaires régionales d'embaucher jusqu'à 2 400 nouveaux membres du personnel infirmier et autres employés de première ligne pour les prochains trois ans. Le budget prévoyait aussi l'ajout de 90 médecins en 2000-2001 et une hausse du nombre de postes de formation postdoctorale dans les facultés de médecine de l'Alberta pour les prochains deux ans. La hausse du financement a également servi à réduire les listes d'attente pour certaines interventions en permettant d'accroître le nombre de chirurgies essentielles et nécessaires à la survie, notamment les chirurgies cardio-vasculaires, les transplantations d'organes importantes, les chirurgies du cancer et les neurochirurgies. Les nouveaux fonds investis dans les soins de santé ont aussi favoriser l'augmentation des services de soins à domicile (20 millions de dollars), des achats de matériels médicaux (49 millions de dollars), des médicaments et des fournitures médicales (29 millions de dollars) et de sang et des produits sanguins (17 millions de dollars).

Les autorités sanitaires régionales ont reçu une hausse de financement de 218 millions de dollars ou de 7,7 pour cent en 2000-2001. Elles ont également reçu une hausse de 47 millions de dollars ou de 18,2 pour cent à l'échelle provinciale pour des services nécessaires à la survie effectués surtout à Edmonton et à Calgary.

En mai 2000, les investissements suivants ont également été faits :

- 54,4 millions de dollars pour réduire les listes d'attente pour les chirurgies à cœur ouvert, les remplacements d'articulation, les examens IRM et les traitements du cancer;
- 64 millions de dollars pour remplacer le matériel médical désuet. Ainsi, un montant total de 112 millions de dollars a été investi pour l'équipement;
- 20 millions de dollars pour élargir les services de soins de longue durée et les services de soins à domicile.

Le portefeuille ministériel a également prévu 39 millions de dollars pour couvrir les coûts des conventions salariales négociées des autorités sanitaires.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

En 2000-2001, quelque 4 856[7] médecins et 2 910[7] autres professionnels des domaines paramédicaux étaient inscrits au régime d'assurance-santé de l'Alberta.

En 2000-2001, les nouvelles initiatives de financement des services médicaux incluaient les suivantes :

- une hausse de 42,8 millions de dollars (4,7 pour cent) des fonds alloués aux services médicaux;
- une hausse de 2,2 millions de dollars (16,7 pour cent) pour les initiatives en milieu rural afin de continuer à améliorer les efforts consentis pour embaucher et maintenir en poste les médecins dans les régions rurales de l'Alberta;
- une hausse de 6,6 millions de dollars alloués à l'enseignement supérieur en médecine;
- huit postes de débutant seront réservés aux diplômés en médecine de l'étranger qui résident en Alberta;

Pour l'exercice 2000-2001, 260 millions de dollars ont été consentis pour ajouter des lits de soins de longue durée et remplacer ou rénover les établissements de santé existants dans la province.

5.4 Rémunération des médecins

Le 20 avril 1998, le ministère de la Santé et du Mieux-être de l'Alberta et l'Association médicale de l'Alberta ont conclu une entente directrice quinquennale régissant la prestation des services médicaux aux Albertains pour la période allant de 1998 à 2004. Cette entente a remplacé toutes les autres ententes alors en vigueur. Dans le cadre de cette entente, qui prévoit les modalités financières pour les exercices 1998-1999, 1999-2000 et 2001-2002, le ministère de la Santé et du Mieux-être impose un plafond révisable pour la rémunération à l'acte des médecins et pour un certain nombre de programmes d'avantages sociaux offerts à ces derniers. L'entente a été ratifiée à la majorité des voix par les membres de l'Association médicale de l'Alberta.

En janvier 2001, le ministère de la Santé et du Mieux-être de l'Alberta et l'Association médicale de l'Alberta ont conclu une entente modifiant l'entente directrice du 20 avril 1998. Les conditions de la nouvelle entente sont en vigueur du 1er avril 2001 au 31 mars 2003, à moins qu'une autre date d'entrée en vigueur ne soit indiquée pour une des conditions. L'entente modifiant l'entente directrice établit les budgets des services médicaux pour les exercices 2001-2002 et 2002-2003, ainsi que le pourcentage qui doit être utilisé pour établir les estimations concernant les hausses démographiques, pour faire les ajustements au plafond révisable du budget des services médicaux.

L'entente modificatrice a établi aussi un fonds pour l'innovation dans le domaine de la prestation des services médicaux pour appuyer l'élaboration d'autres plans de paiement, ainsi qu'un programme de spécialistes sur appel pour rémunérés les spécialistes sur appel et les aider à respecter leur responsabilité qui consiste à assurer que les patients ont accès aux médecins spécialistes. Conformément à l'entente modificatrice, le ministère de la Santé et du Mieux-être de l'Alberta s'est également engagé à établir un fonds d'urgence pour les

[7] NOTA : Ces chiffres seront considérés comme provisoires jusqu'à ce que le portefeuille ministériel de la Santé et du Mieux-être de l'Alberta publie les statistiques supplémentaires de 2000-2001 sur le régime d'assurance-santé de l'Alberta.

médecins sur appel qui sera en vigueur dès le 1er avril 2002 afin de financer les changements qui pourraient s'imposer à la suite de l'examen et de l'évaluation de l'efficacité des programmes à l'intention des médecins sur appel de l'Alberta.

Le paragraphe 4(1) de l'*Alberta Health Care Insurance Act* confère le pouvoir au ministre de payer les avantages sociaux en fonction des services de santé offerts aux résidents de l'Alberta. Aucune modification n'a été apportée à la loi en 2000-2001.

Barème des honoraires

La plupart des médecins en Alberta sont rémunérés à l'acte lorsqu'ils fournissent des services assurés. Certains médecins considèrent le modèle de financement et de rémunération à l'acte restrictif. Le ministère et l'Association médicale de l'Alberta travaillent en collaboration avec les autorités sanitaires, les établissements et les médecins en vue d'élaborer un certain nombre de projets sur des plans de rémunération non traditionnels pour remplacer la rémunération à l'acte. Jusqu'à maintenant, le sous-comité chargé de la question a élaboré quatre nouveaux modèles de financement. Comme pour la rémunération à l'acte, les plans de rémunération non traditionnels sont financés à partir du budget des services médicaux du ministère et ne sont pas à l'annexe A du présent rapport (voir Statistiques sur les régimes d'assurance-santé provinciaux et territoriaux). Dans certains cas, le financement des plans de rémunération non traditionnels et la rémunération à l'acte peuvent être intégrés de manière à rémunérer les médecins pour des services qui ne font pas partie de l'arrangement. Les projets sur des plans de rémunération non traditionnels pourraient aussi être admissibles à une subvention pour couvrir certaines dépenses associées au projet.

Les quatre modèles de financement élaborés par le sous-comité sur les plans de rémunération non traditionnels sont les suivants :

- **Capitation :** Le financement par capitation est habituellement associé à la prestation des soins médicaux primaires. Un financement par habitant est octroyé pour les soins complets de chaque patient pour une période déterminée. Le tarif de capitation est calculé en prenant en considération divers facteurs, notamment l'âge et le sexe des patients et une gamme prédéterminée de services qui seront offerts par la clinique.
- **Rémunération par séance :** Financement fondé sur des unités de temps (par exemple, à l'heure ou quotidien) consacrées à la prestation de services médicaux assurés définis dans le cadre de la structure organisée d'un programme. La rémunération par séance doit faire partie d'un programme exécuté par les autorités sanitaires régionales et doit prévoir et respecter un certain modèle établi de prestation de services.
- **Rémunération contractuelle :** Financement octroyé dans la forme d'un montant forfaitaire pour la prestation d'un volume prédéterminé de services médicaux assurés, pendant une certaine période, telle qu'une année (par exemple, x dollars payés pour la rencontre de cent patients ou la prestation d'un service quelconque répétée 500 fois).
- **Financement global :** Montant négocié versé à un groupe de médecins pour la prestation de tous les services assurés dans un domaine particulier de la médecine au cours d'une période de temps considérable (par exemple, x dollars pour la prestation de tous les services de neurochirurgie dans le nord de l'Alberta sur une période de trois ans).

5.5 Paiements aux hôpitaux

La *Regional Health Authorities Act* expose les exigences relatives à l'établissement et à la gestion publique des autorités sanitaires régionales de l'Alberta.

Aux termes de l'article 8 de la *Regional Health Authorities Act*, l'autorité sanitaire doit présenter au ministre un projet de régime de soins médicaux pour la région. Ce projet doit indiquer la façon dont l'autorité sanitaire propose d'assumer ses responsabilités et de mesurer son rendement à cet égard de même que

contenir de l'information concernant les services de santé à dispenser et le coût anticipé de leur prestation.

Les autorités sanitaires régionales sont financées par le gouvernement provincial à l'aide d'une formule de financement fondée sur la population. Un financement supplémentaire est également accordé aux autorités sanitaires d'Edmonton et de Calgary pour la prestation de services tertiaires spécialisés (services offerts à l'échelle provinciale) à tous les Albertains. En 2000-2001, 3,1 milliards de dollars ont été octroyés aux autorités sanitaires régionales sous forme de financement global (y compris les services offerts à l'échelle provinciale).

Les autorités sanitaires régionales sont responsables de rendre compte et relèvent du ministre de la Santé et du Mieux-être. Le ministre a le pouvoir de demander aux régions les dossiers, les rapports, les relevés financiers ainsi qu'un rapport annuel de leurs activités. Les rapports annuels sont par la suite présentés à l'assemblée législative par le ministre et sont compris dans le rapport annuel du portefeuille ministériel de la Santé et du Mieux-être de l'Alberta.

Aucune modification n'a été apportée à la loi en 2000-2001.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement de l'Alberta a publiquement reconnu les contributions fédérales reçues en vertu du Transfert canadien en matière de santé et de programmes sociaux dans les résultats de 2000-2001, dans le plan d'activités triennal de la province et dans une liste des revenus des états financiers du ministère. Les transferts figurent aussi dans le rapport annuel et le complément statistique du portefeuille ministériel. Tous ces documents sont disponibles soit en communiquant avec l'imprimeur de la Reine ou en consultant notre site Web à www.health.gov.ab.ca ou une bibliothèque publique de la province.

7.0 Services complémentaires de santé

Les centres de soins prolongés de l'Alberta offrent l'hébergement et la pension, ainsi que toute une gamme de services de soins, depuis les soins personnels avec supervision infirmière jusqu'aux services médicaux et thérapeutiques spécialisés. Dans la plupart des cas, les hôpitaux auxiliaires et les maisons de repos sont appelés des centres de soins de longue durée et s'adressent aux résidents ayant des besoins apparentés. Le financement des centres de soins de longue durée relève maintenant de la compétence des 17 autorités sanitaires régionales. Les autorités sanitaires régionales exploitent elles-mêmes les centres de soins de longue durée ou confient la prestation des services à des organismes bénévoles ou à des entrepreneurs.

Le programme de soins à domicile, offert lui aussi par l'entremise des autorités sanitaires régionales, fournit toute une gamme de services de soutien professionnels en vue du maintien ou du retour à domicile des personnes de tous âges. Dans le cadre de ce programme, toutes les autorités sanitaires régionales offrent des services d'évaluation et de coordination des cas, ainsi que des services infirmiers et des services de soutien, comme les soins personnels et l'aide à domicile. D'autres services peuvent parfois être fournis : ergothérapie, physiothérapie, oxygénothérapie, orthophonie, services sociaux et services nutritionnels.

L'admission au système de soins de longue durée, qui comprend les soins à domicile, les centres de soins de longue durée et de soins communautaires et les programmes de jour pour adultes, est fondée sur une évaluation fonctionnelle des besoins de la personne, effectuée à l'aide de l'*Alberta Assessment and Placement Instrument*. La province a adopté le principe du guichet unique pour les personnes qui cherchent des soins de longue durée en établissement ou dans la communauté. Cette démarche a pour but de faire en sorte que toutes les options communautaires possibles soient examinées avant de recourir aux soins en établissement. Le personnel des soins à

domicile procède à une évaluation, détermine les besoins en collaboration avec le client et sa famille et recommande les services de santé et de soutien les plus appropriés.

L'aide de la province à la vie quotidienne

Le ministère de la Santé et du Mieux-être de l'Alberta administre également le programme d'aide à la vie quotidienne de l'Alberta, qui a pour but de favoriser l'autonomie des patients vivant chez eux qui sont atteints d'une maladie chronique, d'une maladie en phase terminale ou d'une invalidité, en leur fournissant du matériel ou des appareils médicaux approuvés par le programme. Des agents approbateurs exerçant dans les secteurs des soins communautaires, des soins prolongés ou des soins actifs évaluent l'admissibilité des clients.

Alberta Mental Health Board, services de santé mentale

Les services de santé mentale sont fournis par l'*Alberta Mental Health Board* (AMHB), par l'intermédiaire des cliniques communautaires, de deux hôpitaux psychiatriques, de deux centres de soins, de 67 cliniques communautaires de santé mentale et de trois bureaux satellites ainsi que divers organismes communautaires à but non lucratif. Les cliniques offrent des services d'évaluation et de traitement aux patients et aux membres de leur famille et des services de consultation aux médecins, aux établissements de santé, aux unités de santé, aux écoles et aux organismes communautaires. Les deux hôpitaux psychiatriques offrent des services d'évaluation, de traitement et de réadaptation aux adultes, y compris les délinquants atteints d'une maladie mentale et les adultes souffrant d'une lésion cérébrale. Les deux centres de soins en établissement fournissent des programmes de réadaptation à long terme aux personnes souffrant d'une maladie mentale grave. L'AMHB assure aussi la direction de quatre programmes provinciaux de santé mentale : psychiatrie médicolégale, psychiatrie gériatrique, soins tertiaires pour adultes et traumatismes crâniens.

Les autorités sanitaires régionales fournissent également des services psychiatriques spécialisés par l'entremise de 17 hôpitaux de la province. Enfin, les médecins de famille, les programmes de soins à domicile et les centres de soins de longue durée fournissent aussi des services aux personnes atteintes d'une maladie mentale.

Alberta Cancer Board

En 2000-2001, le ministère a versé 123,8 millions de dollars à l'*Alberta Cancer Board* pour l'aider à financer son fonctionnement et ses différents programmes de recherche.

Documents supplémentaires présentés à Santé Canada

Listes des services hospitaliers, médicaux et de chirurgie dentaire non assurés :

- *Schedule of Medical Benefits, 2001*;
- *Schedule of Oral and Maxillofacial Surgery Benefits, 2001*;
- Rapports de 1999-2000 et de 2000-2001 du vérificateur général de l'Alberta.

Regroupement de toutes les lois relatives au régime d'assurance-santé, telles que présentées dans la section sur l'administration publique de notre exposé, ainsi que les réglements connexes :

- *Alberta Health Care Insurance Act*;
- Alberta Health Care Insurance Regulation;
- *Government Accountability Act*;
- *Health Care Protection Act*;
- Health Care Protection Regulation;
- *Health Insurance Premiums Act*;
- Health Insurance Premiums Regulation;
- Hospitalization Benefits Regulation;
- *Hospitals Act*;
- Hospital Foundations Regulation;
- Medical Benefits Regulation;
- *Medical Profession Act*;
- *Nursing Homes Act*;
- Nursing Homes General Regulation;
- *Regional Health Authorities Act*;
- Regional Health Authorities Regulation.

Rapports témoignant des contributions du gouvernement fédéral au titre du Transfert canadien en matière de santé et de programmes sociaux :

- *Alberta Health Care Insurance Plan Statistical Supplement, 1999-2000*;
- *Alberta Ministry of Health and Wellness Annual Report, 1999-2000*;
- *Ministry of Health and Wellness Three-Year Business Plan, 2001-2004*;
- Budget de l'Alberta, 2000-2001.

Colombie-Britannique

Introduction

La Colombie-Britannique est pourvu d'un système de santé progressif et intégré fondé sur des collèges professionnels auto-réglementés qui offrent des services de santé accessibles, abordables et de qualité dans toutes les régions. Le régime d'assurance-santé de la Colombie-Britannique comprend les services assurés en vertu de la *Loi canadienne sur la santé* ainsi que les services entièrement financés par le gouvernement de la Colombie-Britannique. Les instances responsables des services de santé s'occupent de la prestation et de la gestion des services de santé dans chaque collectivité de la Colombie-Britannique. Au 31 mars 2001, elles comptaient 11 conseils de santé régionaux, 34 conseils de santé communautaire et 7 sociétés de services de santé communautaire dans toute la province. Les soins de santé sont la priorité numéro un du gouvernement et de la population de la Colombie-Britannique. Les services de santé offerts dans la province comprennent des services complètement ou partiellement financés par le gouvernement ainsi que des services réglementés mais non financés par le gouvernement.

Activités en 2000-2001

Durant l'année 2000-2001, le ministère de la Santé s'est concentré sur la prestation de services de santé de qualité, en temps opportun, en Colombie-Britannique. L'un des problèmes essentiels à cet égard était le recrutement de médecins, d'infirmières et d'autres professionnels de la santé dans les régions où l'on en avait besoin. Le système de santé provincial a également mis l'accent sur la réponse aux besoins d'une population vieillissante et sur l'élaboration de moyens novateurs pour faire face au besoin croissant d'un système qui soit adapté aux personnes âgées et respectueux de ces dernières. La nécessité de répondre à ces enjeux a conduit le gouvernement à établir des partenariats plus solides entre le ministère de la Santé, les instances responsables des services de santé et des intervenants clés et de trouver des moyens nouveaux et efficaces pour offrir les soins accessibles et de haute qualité dont la population a besoin.

Un certain nombre de mesures ont été prises en 2000-2001 pour améliorer l'accès et pour réduire les périodes d'attente aux services hospitaliers assurés. À l'aide, en partie, des fonds reçus du gouvernement fédéral, la Colombie-Britannique a fait l'acquisition de 15 tomodensitomètres et 11 machines IRM. Ces dernières acquisitions ont fait passer le nombre total de machines IRM de 7 à 16, faisant ainsi plus que doubler la capacité de la Colombie-Britannique.

Un vaste éventail de projets relatifs aux immobilisations ont été financé afin de permettre la création et l'amélioration d'établissements de soins de santé.

Changements prévus en 2001-2002

Le 5 juin 2001, le ministère de la Santé et ministère responsable des personnes âgées a été réorganisé en deux nouveaux ministères dans le but de répondre aux enjeux de la santé et d'améliorer les soins de santé en Colombie-Britannique. Le ministère des Services de santé subventionne et gère le budget de la santé, oriente de manière stratégique le système de santé et offre un leadership en ce a trait à la prestation de services de soins de santé, de santé préventive et de promotion de la santé en Colombie-Britannique. Le ministère de la Planification de la santé soutient la planification à long terme nécessaire pour assurer la viabilité du système de santé public de la Colombie-Britannique dans les années à venir.

Les renseignements sur la santé et les soins de santé en Colombie-Britannique sont disponibles sur les sites Web de ces deux ministères, aux adresses suivantes.

www.gov.bc.ca/healthservices/
www.gov.bc.ca/healthplanning/

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le 1er janvier 1949, le gouvernement provincial de la Colombie-Britannique promulguait la *Hospital Insurance Act*, laquelle détermine le paiement des traitements fournis aux résidents admissibles. Les services hospitaliers sont financés, sans but lucratif, par la *Regional Programs Division* du ministère de la Santé. Le régime est responsable au nom du gouvernement provincial en ce qui a trait au financement public continu des services hospitaliers publics de la province dispensés par l'entremise des accords de financement et de transfert conclus avec les instances responsables des services de santé dans les régions, conformément à la *Hospital Act*, à la *Hospital Insurance Act* et à la *Hospital District Act*. Ces dernières régissent le contrôle des dépenses et des engagements pour le fonctionnement des hôpitaux (fusionnés ou non) et des sociétés d'établissements désignés, le financement pour la construction d'hôpitaux et l'équipement et le remboursement des coûts hospitaliers fournis hors province aux résidents admissibles de la Colombie-Britannique.

Le régime de soins médicaux de la Colombie-Britannique, le *Medical Service Plan* (MSP), est géré sans but lucratif par la *Medical Services Commission*, organisme relevant du ministre des Services de santé qui favorise, conformément à la *Medicare Protection Act* (1996), un accès raisonnable aux services assurés fournis aux prestataires (résidents) admissibles dans le cadre du régime de soins médicaux de la Colombie-Britannique. Le personnel du ministère des Services de santé responsable du régime de soins médicaux veille à sa gestion quotidienne.

La Commission dispose de l'autorité pour déterminer les services offerts, inscrire les prestataires, embaucher les médecins, traiter et payer les réclamations des médecins pour les services fournis, inscrire les centres de diagnostic, négocier les accords avec les médecins et leurs associations, mettre sur pied des comités consultatifs, autoriser des recherches et des enquêtes relatives à la prestation de services, vérifier ou enquêter sur la facturation et les modèles de pratique des médecins par rapport aux réclamations présentées et entendre les demandes d'appel formulées par les médecins et les prestataires.

1.2 Liens hiérarchiques

Les instances responsables des services de santé doivent présenter des rapports sur les données sur la santé afférentes aux hôpitaux de leurs juridictions à l'intention du ministère de la Santé, conformément à la politique provinciale. Les hôpitaux non fusionnés doivent faire de même, en plus de les présenter à l'autorité régionale responsable de la santé, conformément à la demande formulée par cette dernière. La *Regional Programs Division* en fait rapport au gouvernement par l'entremise du rapport annuel du ministère de la Santé.

La *Medical Services Commission* présente un rapport annuel contenant un état financier distinct à l'intention du ministre. Cet état financier fait partie du rapport annuel du ministère de la Santé. Le rapport annuel de 1999-2000 a été déposé le 9 février 2001.

Dans son rapport annuel sur le rendement, le ministère de la Santé a produit de l'information complète sur le rendement du système de santé financé par le secteur public de la Colombie-Britannique. La collecte et le rapport de cette information s'inscrivent dans l'approche stratégique du Ministère et dans le cadre de ses responsabilités à l'égard de la planification du rendement et de la production de rapports en vertu de la *Budget Transparency and Accountability Act*.

1.3 Vérification des comptes

La *Regional Programs Division* et la *Medical Services Commission* peuvent voir leurs comptes et leurs opérations financières vérifiés de trois façons. À l'interne, la *Financial Policy and Monitoring Branch* du ministère de la Santé examine les activités ministérielles.

La *Internal Audit Branch* du Bureau du contrôleur général est le vérificateur interne

du gouvernement provincial, et le Bureau du vérificateur général (BVG) de la Colombie-Britannique est chargé de mener des vérifications et d'en présenter les résultats à l'assemblée législative.

Le BVG amorce ses propres vérifications et détermine leur portée. Le Comité des comptes publics de l'assemblée législative examine les recommandations formulées par le vérificateur général et détermine quand le Ministère se conforme aux constatations. Le contrôleur général détermine la portée des vérifications internes et le moment où elles ont lieu, en collaboration avec le comité de vérification du ministère de la Santé. L'agent financier supérieur du Ministère détermine la portée et le moment où les examens seront menés par la *Financial Policy and Monitoring Branch*.

2.0 Intégralité

2.1 Services hospitaliers assurés

La *Hospital Insurance Act* régit les services hospitaliers assurés fournis par les établissements. En 2000-2001, la Loi touchait 94 hôpitaux de soins actifs, 3 hôpitaux de réadaptation, 18 hôpitaux de soins prolongés autonomes et 25 centres de diagnostic et de traitement et autres centres de santé.

Les services assurés aux patients hospitalisés comprennent : l'hébergement et les repas en salle commune; les services infirmiers nécessaires; les services de laboratoire et de radiologie, les interprétations nécessaires ainsi que tout autre service de diagnostic approuvés par le Ministre; les médicaments, les produits biologiques et les fournitures médicales approuvés en clinique lorsqu'ils sont administrés dans un hôpital général précisé dans la *Hospital Insurance Act*; les fournitures chirurgicales courantes; l'usage des salles d'opération et des salles d'accouchement; le matériel et les fournitures d'anesthésie; l'usage des installations de radiothérapie, de physiothérapie et d'ergothérapie là où elles existent; d'autres services approuvés par le Ministre et dispensés par des personnes rémunérées à cette fin par l'hôpital. Les personnes admissibles qu'il n'est pas nécessaire d'hospitaliser peuvent recevoir des traitements d'urgence pour des blessures ou des maladies et des services de salles d'opération ou d'urgence pour des interventions mineures et les soins chirurgicaux de jour, y compris l'application et l'enlèvement des plâtres.

Les services de consultation externe comprennent : les traitements d'hémodialyse dans des hôpitaux désignés ou dans d'autres établissements approuvés; les soins de jour pour diabétiques dans les hôpitaux désignés; les conseils en diététique pour patients externes dans des hôpitaux qui emploient des diététiciens compétents; des services psychiatriques et les soins de jour pour patients externes; les soins de jour de physiothérapie et de réadaptation pour les patients externes; les traitements du cancer et les services de cytologie; les consultations externes pour le traitement du psoriasis; les services d'avortement et d'IRM.

Les services hospitaliers assurés sont fournis sans frais. Les frais supplémentaires pour les fournitures médicales ou de chirurgie préférées sont fondés sur une demande du malade. Le malade n'a pas à assumer les frais supplémentaires si le service recommandé est évalué comme nécessaire sur le plan médical par son médecin traitant.

Les services d'ambulance sont fournis dans la province par le ministère de la Santé de la Colombie-Britannique, par l'entremise de la *Emergency Health Services Commission*. Le patient paie une somme nominale.

En 2000-2001, aucun nouveau service n'a été ajouté à la liste des services hospitaliers assurés couverts en vertu de la *Hospital Insurance Act*.

2.2 Services médicaux assurés

Les services médicaux assurés sont fournis en vertu de la *Medicare Protection Act* (1996). Le régime de soins médicaux offre tous les services nécessaires sur le plan médical. La vaste gamme des services assurés comprend les consultations, les examens complets, les consultations à domicile, les chirurgies mineures ou importantes, les services

d'obstétrique, l'assistance en matière de chirurgie, l'anesthésie, les interventions thérapeutiques ou de diagnostic, les services spéciaux ou divers, d'autres procédures administratives et d'autres procédures d'hôpital fournies par le médecin.

Pour exercer en Colombie-Britannique, les médecins doivent être inscrits au *College of Physicians and Surgeons of British Columbia* et en être des membres en règle. Pour recevoir un paiement pour des services assurés, ils doivent être inscrits au régime de soins médicaux. En mars 2001, 7 658 médecins y étaient inscrits et étaient rémunérés à l'acte pour l'exercice 2000-2001. En outre, certains médecins n'étaient que salariés ou recevaient une rémunération à la vacation. La plupart des médecins rémunérés par l'entremise de mécanismes de rechange recevaient également une rémunération à l'acte.

Un médecin peut choisir de ne pas s'inscrire à la *Medical Services Commission* ou, encore, de s'en retirer. Les médecins inscrits peuvent annuler leur inscription en donnant un préavis écrit de 30 jours à la Commission. Les services fournis par les médecins non inscrits ne sont pas des services assurés et les patients doivent en assumer les coûts. Au 31 mars 2000, un seul médecin inscrit s'était retiré de la Commission.

Les médecins inscrits peuvent choisir d'être payés directement par les patients, moyennant un avis écrit à la *Medical Services Commission* (MSP). De 30 à 45 jours suivant la réception de l'avis, la Commission communiquera la date de mise en vigueur de cette méthode de rémunération. Dans ce cas, les patients peuvent présenter une demande au MSP pour obtenir le remboursement des frais des services assurés fournis. Au 31 mars 2001, seulement huit médecins ne participaient pas à ce type de rémunération.

2.3 Services de chirurgie dentaire assurés

Le régime de soins médicaux offre des services déterminés de chirurgie buccale et dentaire, lorsqu'ils sont nécessaire sur le plan médical ou de la dentisterie et fournis dans un hôpital par un chirurgien dentiste/stomatologiste. Tout chirurgien dentiste ou stomatologiste inscrit au *College of Dental Surgeons* et y étant un membre en règle et inscrits au MSP, qui offre un ou plusieurs des services limités de chirurgie dentale assurés dans un hôpital peut offrir ce service. En 2000-2001, il y avait 283 chirurgiens dentistes et 3 chirurgiens stomatologistes inscrits au régime et aucun d'eux n'a décidé de se retirer du MSP.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Pour les patients externes, les médicaments emportés à domicile et certains médicaments fournis à l'hôpital ne sont pas assurés, sauf ceux qui sont fournis en vertu du programme Pharmacare (programme de services pharmaceutiques). D'autres services sont exclus en vertu de la *Hospital Insurance Act* : les services diagnostiques de consultation externe non associés aux services d'urgence; les services fournis par le personnel médical qui n'est pas employé par l'hôpital; les traitements pris en charge par la *Workers' Compensation Board*, le ministère des Anciens combattants ou tout autre organisme; les services à des fins purement esthétiques et le rétablissement de la fécondité. Les services hospitaliers non assurés comprennent également des installations préférées demandées par le patient : télévision, téléphone et services infirmiers privés; des fournitures médicales ou de chirurgie préférées; des soins dentaires pouvant être fournis dans une clinique dentaire, y compris les services de prothèse et d'orthodontie et les services préférés fournis aux malades dispensés dans des unités/hôpitaux de soins prolongés.

Les services suivants ne sont pas assurés : les services assurés en vertu de la *Worker's Compensation Act* ou d'une autre loi provinciale ou fédérale; la fourniture de prothèses non implantées; les orthèses; les spécialités pharmaceutiques et les médicaments brevetés; toute demande d'examen ou de certificat médical faite par un tiers; la chirurgie buccale réalisée dans un cabinet de dentiste; l'acuponcture; les vaccinations de groupe; les consultations téléphoniques; le rétablissement de la fécondité; la fécondité *in vitro*; les services

médico-légaux; les services dispensés à des fins esthétiques; les services de conseils en médecine préventive comme, par exemple, les programmes contre le tabagisme.

Pour obtenir des services hospitaliers ou médicaux, ces derniers doivent être considérés comme essentiels sur le plan médical par le médecin traitant et par l'hôpital. Le statut du patient en tant que client d'un tiers payeur ne doit pas aller à l'encontre de cette définition. Ainsi, les tiers payeurs ne reçoivent pas un accès prioritaire aux services assurés par rapport aux personnes assurées.

L'article 45 de la *Medicare Protection Act* interdit la vente ou la délivrance d'une police d'assurance-santé par un assureur privé à des prestataires pour des services qui seraient considérés comme des services assurés s'ils étaient fournis par un médecin. L'article 17 de la *Medicare Protection Act* empêche d'exiger le paiement de fournitures, de consultations, de l'utilisation d'un bureau, d'une clinique ou de tout autre endroit ou pour toute affaire relative à la prestation d'un service. Le ministère de la Santé répond aux plaintes formulées par les patients et prend les mesures appropriées pour corriger les situations signalées au Ministère.

La *Medical Services Commission* détermine les services assurés en vertu du régime de soins médicaux et détient l'autorité de supprimer de la liste certains services assurés. Des propositions de suppression peuvent être formulées auprès de la Commission. Des consultations peuvent être tenues par l'entremise d'un sous-comité de la Commission et comprennent habituellement un examen du comité des tarifs de la *British Columbia Medical Association*.

3.0 Universalité

3.1 Admissibilité au régime

Les articles 2, 3, 4, 6 et 7 de la *Hospital Insurance Act* et les articles 1, 3, 4 et 9.3 des *Règlements* définissent les modalités et les exigences en matière d'admissibilité aux services hospitaliers assurés. La politique provinciale sur l'admissibilité aux services hospitaliers est définie dans le chapitre 2 du *Acute Care Policy Manual* du Ministre.

L'admissibilité et l'inscription des prestataires de services médicaux assurés sont définies dans la *Medicare Protection Act*. La deuxième partie des règlements d'application de la Loi (*Medical and Health Care Services Regulations*) expose les détails en matière de résidence. Une personne doit être résidente de la Colombie-Britannique pour pouvoir recevoir des services de soins de santé provinciaux assurés. En vertu de la *Medicare Protection Act*, un résident est une personne qui est citoyenne canadienne ou qui est légalement autorisée à être au Canada en tant que résidente permanente, qui élit domicile en Colombie-Britannique et qui y demeure au moins six mois par année civile. La définition d'un résident comprend la personne qui est considérée comme telle par les règlements, mais ne comprend pas les touristes ou les visiteurs en Colombie-Britannique.

Tous les résidents, à l'exception des personnes qui sont admissibles à une couverture d'une autre source, ont droit à l'assurance-hospitalisation et à l'assurance pour les soins médicaux.

Les membres libérés de la Gendarmerie Royale du Canada et des Forces canadiennes ainsi que les détenus fédéraux libérés sont protégés dès le premier jour de leur libération. Toutefois, s'ils se trouvent alors en dehors de la Colombie-Britannique, ils se voient imposer le délai d'attente prescrit par la Loi.

3.2 Exigences relatives à l'inscription au régime

Depuis le 1er avril 1998, les habitants doivent être inscrits au régime de soins médicaux afin de bénéficier des services médicaux et hospitaliers assurés. Les personnes admissibles doivent s'y inscrire. Une fois l'inscription faite, il n'y a pas de date limite. On recommande aux nouveaux résidents de s'inscrire immédiatement après leur arrivée dans la province. Chaque personne qui s'inscrit au régime de soins médicaux reçoit une carte santé. Habituellement, il est possible de renouveler une inscription annulée par

téléphone auprès du personnel responsable du régime de soins médicaux.

Les personnes à charge des prestataires peuvent être protégées, à condition que ces dernières résident dans la province. Les personnes à charge comprennent la conjointe ou le conjoint du titulaire (soit par mariage ou vivant en concubinage), tout enfant ou enfant en tutelle célibataire de moins de 19 ans à la charge du prestataire ou une personne de moins de 25 ans qui étudie à temps plein dans une école ou une université.
Au 31 mars 2001, 4,02 millions de personnes étaient inscrites au régime de soins médicaux.

L'inscription au régime de soins médicaux est obligatoire. Seuls les adultes qui demandent à ne pas participer au programme de santé provincial sont exemptés. Au 31 mars 2001, 150 personnes avaient choisi de ne pas y participer.

3.3 Autres catégories de personnes

Habituellement, les demandeurs du statut de réfugié ne sont pas admissibles. Les personnes qui ont reçu le statut de réfugié et qui ont, ainsi, le droit de résider au Canada de façon permanente peuvent s'inscrire au régime de soins médicaux. Dans des circonstances particulières, une attention spéciale est accordée à ces personnes en ce qui a trait à la date de mise en application du régime. Les titulaires de permis ministériels peuvent accéder aux services s'ils sont considérés comme résidents en vertu des *Medical and Health Care Services Regulation*. Dans ce cas, une période d'attente s'applique.

3.4 Primes

Il est obligatoire de s'inscrire au régime de soins médicaux, et le versement de primes est habituellement l'une des conditions d'admissibilité. Cependant, le fait de ne pas verser de primes ne compromet pas l'accès au régime si la personne satisfait aux conditions d'admissibilités de base. Les primes mensuelles du régime sont de 36 dollars pour une personne seule, de 64 dollars pour une famille de deux personnes et de 72 dollars pour une famille de trois personnes ou plus. Les personnes à faible revenu peuvent être admissibles à une réduction. Il existe cinq niveaux d'aide, allant de 20 p. 100 à 100 p. 100 de la prime fixée. Seules les personnes qui ont habité au Canada pendant au moins douze mois consécutifs et qui sont citoyennes canadiennes ou qui ont le statut de résident permanent (immigrant reçu) peuvent recevoir de l'aide pour pouvoir assumer leur prime.

Il n'y a pas de primes supplémentaires pour les services hospitaliers assurés, mais il y a des frais quotidiens pour les soins hospitaliers prolongés dispensés aux patients de plus de 19 ans. Le montant de ces frais, qui couvrent l'hébergement et les repas, est établi une fois par année. Au 31 mars 2001, le taux maximum était de 50 $ par jour. Les résidents qui possèdent des moyens limités sont admissibles à une aide, selon une échelle progressive; cette aide s'établit à 85 pour cent de la Sécurité de la vieillesse et du Supplément de revenu garanti. Dans certaines circonstances, il existe une disposition permettant de se soustraire au paiement d'une partie des frais de 25,9 $. Les taux inférieurs à 50 $ par jour sont révisés tous les trimestres, et les patients sont avisés de tout changement apporté un mois avant qu'il devienne effectif.

4.0 Transférabilité

Les personnes qui déménagent dans une autre province canadienne sont couvertes jusqu'à la fin du deuxième mois suivant leur départ. Leur protection peut être prolongée, (pas plus de trois mois), pendant une période raisonnable de déplacement.

Les personnes qui quittent définitivement le Canada sont couvertes jusqu'à la fin du mois de leur départ.

4.1 Délai minimal de résidence

Pour être admissible à la couverture d'assurance-hospitalisation et de soins médicaux, le délai minimal de résidence est une période d'attente se terminant à minuit le dernier jour du deuxième mois suivant le mois

durant lequel la personne devient une résidente de la province.

Après la période d'attente, les personnes qui ont reçu le statut de résidents permanents sont admissibles. De même, sont admissibles les personnes de l'extérieur du Canada qui résident dans la province grâce à des permis de travail ou à des visas d'étudiants, à condition que les permis ou visas soient valides pour au moins six mois et qu'ils aient été délivrés au moment de l'entrée au Canada.

4.2 Couverture durant des absences temporaires (au Canada)

Les articles 3, 4 et 5 des *Medical and Health Care Services Regulations* définissent les dispositions en matière de transférabilité des services médicaux assurés pour les personnes qui s'absentent temporairement de la Colombie-Britannique, mais qui demeurent au Canada. L'article 17 de la *Hospital Insurance Act* permet au ministre de la Santé de conclure un accord avec n'importe quelle autre province de façon à atteindre un haut niveau de liens et de coopération entre les provinces au sujet de l'assurance-hospitalisation et de prendre des dispositions pour qu'une personne admissible puisse élire domicile dans une province ou l'autre sans cesser d'avoir droit aux services.

Les personnes qui quittent la province temporairement pour prendre des vacances prolongées ou pour occuper un emploi temporaire peuvent être couvertes pendant une période maximale de 12 mois. Une seule approbation est accordée pour chaque période de cinq ans dans le cas d'absences de plus de six mois durant une année civile. Les résidents qui sont absents de la Colombie-Britannique pendant une partie de l'année, chaque année, doivent demeurer au Canada pendant au moins six mois de chaque année civile et maintenir leur domicile en Colombie-Britannique. Les personnes qui étudient à temps plein dans une école reconnue dans une autre province sont couverts pendant la durée de leurs études.

En vertu des ententes de facturation réciproque interprovinciale et interterritoriale, les médecins, à l'exception de ceux du Québec, facturent directement leurs régimes pour les services dispensés aux habitants admissibles de la Colombie-Britannique lorsque ceux-ci présentent leur carte valide du régime de soins médicaux, la carte santé. La Colombie-Britannique rembourse les frais à la province ou au territoire au taux fixé en vertu du barème d'honoraires de la province ou du territoire dans lequel les services ont été rendus.

Les frais pour les soins dispensés à des patients hospitalisés sont remboursés au taux standard d'une chambre régulière facturé réellement par les hôpitaux. Pour les services externes, le paiement correspond au taux de facturation réciproque entre les provinces et les territoires. Le paiement de ces services, sauf pour les services exclus facturés au patient, se fait par l'entremise des mécanismes de facturation réciproque entre toutes les provinces.

La section sur l'administration publique du *Acute Care Policy Manual* expose les détails particuliers de l'entente actuelle de facturation réciproque interprovinciale et interterritoriale pour les services hospitaliers assurés. À l'exception du Québec, qui n'a pas signé l'entente, chaque régime d'assurance-hospitalisation provincial traitera les comptes des malades hospitalisés et des malades externes au nom des résidents de l'autre province ou territoire. L'entente couvre les services fournis à l'intérieur des frontières des provinces ou des territoires et prévoit l'établissement périodique des comptes entre ces derniers.

4.3 Couverture durant des absences temporaires (à l'étranger)

Les règlements d'application de la *Hospital Insurance Act* et les articles 3, 4 et 5 des *Medical and Health Care Services Regulations* définissent la transférabilité des services hospitaliers et médicaux assurés à l'extérieur du Canada.

Une personne admissible qui quitte la Colombie-Britannique pour étudier à temps plein dans une université, un collège ou un autre établissement d'enseignement reconnu par la *Medical Services Commission* reste admissible aux services pendant la durée de son absence jusqu'au dernier jour du mois qu'elle étudiait à temps plein dans cet établissement ou, encore, si elle étudiait à l'extérieur du Canada, jusqu'au dernier jour du 60e mois depuis la date de son départ de la Colombie-Britannique.

Une personne admissible qui quitte la Colombie-Britannique pour prendre des vacances ou pour aller travailler pendant plus de six mois est considérée comme résidente pour les besoins de détermination de son statut de prestataire durant les premiers douze mois consécutifs de son absence, si elle obtient une autorisation préalable de la Commission, n'élit pas domicile à l'extérieur de la Colombie-Britannique et n'a pas reçu d'autorisation pour une absence similaire au cours des 60 mois précédents.

Moyennant une autorisation préalable, les services hospitaliers qui ne peuvent pas être obtenus au Canada sont couverts aux taux courants et habituels des hôpitaux. Dans d'autres circonstances, sous réserve d'une autorisation préalable, les soins dispensés à un patient hospitalisé sont couverts au taux établi pour les lits en salle commune. Les services de jour d'hémodialyse rénale peuvent être couverts au taux canadien prévu par les provinces et les territoires dans les ententes de facturation réciproque. Dans tous les autres cas, y compris les urgences et les maladies subites survenues pendant une absence temporaire de la province, les soins aux patients hospitalisés sont payés jusqu'à concurrence de 75 dollars canadiens par jour pour les adultes et les enfants et de 41 dollars canadiens pour les nouveau-nés.

En cas d'urgence ou de maladie subite, les services médicaux dispensés à l'étranger sont couverts pour les personnes admissibles temporairement absentes de la province. Les services médicaux sont payés jusqu'à concurrence du taux qui aurait été appliqué si le service avait été fourni en Colombie-Britannique, exception faite des cas autorisés d'avance en raison de circonstances particulières. Ils sont alors payés au taux en vigueur à l'endroit où le service est offert. Moyennant une autorisation préalable, le paiement des services médicaux non urgents dispensés à l'étranger peut se faire aux taux courants et habituels lorsque le service approprié n'est pas offert dans la province ou ailleurs au Canada.

4.4 Nécessité d'une approbation préalable

Aucune autorisation préalable n'est requise pour être admissible aux services facultatifs couverts en vertu des ententes de facturation réciproque interprovinciales. Par contre, une autorisation préalable de la Commission est nécessaire pour les services qui ne sont pas assurés dans le cadre de ces ententes. Certains traitements (p. ex., pour les cas d'anorexie) exigent l'autorisation de *Regional Programs*. Tous les services non urgents fournis à l'étranger doivent être approuvés par la Commission avant la prestation du service.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Le gouvernement de la Colombie-Britannique estime offrir un accès raisonnable aux services hospitaliers et aux soins de santé. Les prestataires, tels que définis dans la *Medicare Protection Act* et le *Acute Care Policy Manual* du Ministre, sont admissibles à tous les services hospitaliers et médicaux nécessaires. Pour assurer un accès équitable, sans égard au revenu des malades, l'article 17 de la *Medicare Protection Act* interdit la surfacturation des services médicaux par les médecins inscrits.

5.2 Accès aux services hospitaliers assurés

En 2000-2001, 8 994 lits de soins actifs étaient répartis parmi les 94 établissements de soins actifs et, des 474 lits de réadaptation

disponibles, 176 étaient repartis parmi les trois établissements spécialisés de soins de réadaptation. Par ailleurs, la province disposait de 25 centres de diagnostic et de traitement et de six postes de la Croix-Rouge.

La province donne également accès à des services de soins prolongés. En 2000-2001, on comptait 17 établissements autonomes de soins prolongés. Ces unités de soins et les lits des hôpitaux de soins actifs et de réadaptation connexes représentaient un total de 9 102 lits de soins prolongés.

En décembre 2000, on comptait 28 616 infirmières autorisées. Les hôpitaux de la Colombie-Britannique emploient également des infirmières psychiatriques autorisées et des infirmières auxiliaires autorisées. En 2000, on dénombrait 2 203 infirmières psychiatriques autorisées et 4 496 infirmières auxiliaires autorisées.

Le document intitulé *Capital Planning Requirements for Health Authorities* définit les attentes du ministère de la Santé en ce qui a trait à la planification des immobilisations des instances responsables des services de santé. Le document présente les processus, les politiques, les échéanciers et les rôles et responsabilités liés aux projets immobiliers en santé. Les exigences s'appliquent à tous les types d'établissement de soins de santé, aux centres de santé communautaire, aux postes d'ambulances et aux établissements psychiatriques.

La planification des fonds immobiliers doit correspondre à la vision, à la mission, à l'évaluation des besoins, aux questions prioritaires, aux buts et aux stratégies de l'instance responsable des services de santé, tels que définis dans leurs plans de services de santé triennaux. Le plan de services de santé, combiné à l'âge et à l'état des éléments de l'inventaire physique de l'instance responsable des services de santé, déterminera l'orientation de la planification des immobilisations dans un domaine défini. En juin 2000, l'instance responsable de la santé a présenté des plans triennaux relatifs aux projets immobiliers pour la période allant de 2001 à 2004. Ces plans comprennent les exigences prévues en matière d'immobilisations pour cette période de trois ans dans le contexte de l'orientation stratégique de l'instance responsable de la santé.

La responsabilité gouvernementale en matière de projets d'immobilisations en santé est partagée entre le ministère de la Santé et le ministère des Finances et des Relations avec les entreprises. Le ministère de la Santé veille à l'évaluation et à la planification des besoins; tandis que la Direction générale de la mise en œuvre du ministère des Finances et des Relations avec les entreprises est responsable de la gestion de projet, de l'administration financière et de l'exécution de projet.

Les districts hospitaliers régionaux partagent, avec le gouvernement provincial, les coûts d'immobilisation associés aux établissements de santé régis en vertu de la *Hospital Act*. Cette contribution est assumée par les contribuables, par l'entremise des taxes foncières prélevées par les districts régionaux composés de directeurs de la municipalité et de la circonscription soumis à la *Regional Hospital District Act*.

Un certain nombre de mesures ont été prises en 2000-2001 pour améliorer l'accès et pour réduire les périodes d'attente aux services hospitaliers assurés. À l'aide, en partie, des fonds reçus du gouvernement fédéral, la Colombie-Britannique a fait l'acquisition de 15 tomodensitomètres et 11 machines IRM. Ces dernières acquisitions ont fait passer le nombre total de machines IRM de 7 à 16, faisant ainsi plus que doubler la capacité de la Colombie-Britannique.

On a financé un vaste éventail de projets relatifs aux immobilisations afin de permettre la création et l'amélioration d'établissements de soins de santé en Colombie-Britannique. D'importants projets entrepris par le ministère de la Santé en 2000-2001 comprenaient les suivants.

- Le nouveau centre de lutte contre le cancer de l'île de Vancouver de la B.C. Cancer Agency a ouvert ses portes en mars 2001. Le nouveau centre accroît de 20 pour cent la capacité de traitement des résidents de l'île et réduit les pressions exercées sur les services dans les autres centres de lutte contre le cancer de la province. Le ministère de la Santé a contribué pour 39,3 millions de

dollars à la construction du nouveau centre et à l'acquisition de l'équipement. Le Ministère a également octroyé 1,9 million de dollars pour couvrir les frais de démarrage et une subvention unique de 400 000 dollars pour couvrir les frais d'exploitation afin que le centre puisse ouvrir rapidement, dès la fin de sa construction.

- Une nouvelle aile et un centre de santé pour enfants ont ouvert leurs portes au Surrey Memorial Hospital. La nouvelle aile fait accroître le nombre de salles d'opération, de lits pour hospitalisés et de lits pour prématurés dans la pouponnière. Le ministère de la Santé a octroyé un financement total de 76,5 millions de dollars pour aider à financer les dépenses en immobilisations de l'hôpital.
- Le nouveau Ambulatory Care Building du B.C. Children Hospital était en cours de construction durant l'exercice 2000-2001.
- Des travaux d'agrandissement et de rénovation ont été entrepris au Prince George Regional Hospital. Ce projet comprend la construction d'une tour de quatre étages réservée aux services médicaux chirurgicaux, l'ajout de services destinés aux malades externes, l'agrandissement des unités de l'hémodialyse et de la pédiatrie et la mise à jour du service d'urgence.
- Les travaux d'agrandissement des installations destinées aux soins ambulatoires ont débuté au Trail Regional Hospital. La nouvelle unité de 6,7 millions de dollars permettra la prestation d'un vaste éventail de services aux malades externes, notamment des soins chirurgicaux de jour, de même que la construction d'un bloc opératoire et l'agrandissement des installations réservées aux services d'urgence.
- Les travaux ont débuté avec le projet de rénovation et d'agrandissement de 3,5 millions de dollars au Golden and District General Hospital. Les améliorations apportées à l'hôpital comprendront l'agrandissement et la rénovation des installations d'urgence et de l'entrée principale de même que d'importantes mises à jour mécaniques et électriques.
- Eagle Ridge Manor, un nouvel ajout où sont dispensés des soins multiniveaux du Port Hardy Hospital, a ouvert ses portes en juillet 2000. Le foyer offre des soins 24 heures sur 24 aux résidents dans un milieu de type familial.
- La construction du nouveau Cormorant Island Health Centre, dont les coûts s'établissent à 5,6 millions de dollars, a débuté. Le Centre remplacera le St. George's Hospital d'Alert Bay et offrira des soins actifs, des lits pour soins multiniveaux, des installations de diagnostic et de traitement, des programmes de santé communautaire et des services de soutien.

En outre, la Colombie-Britannique a lancé le programme BC HealthGuide. Au départ, le *Health Guide* (Guide sur la santé) a été distribué à chaque ménage de la Colombie-Britannique. Ce « guide de l'utilisateur » est complété par une base de données en ligne accessible à toutes les personnes possédant un numéro de carte santé personnel de la Colombie-Britannique et une ligne d'information sans frais sur la santé, opérationnelle 24 heures sur 24 et sept jours sur sept dans l'ensemble de la Colombie-Britannique.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

En 2000-2001, 4 360 omnipraticiens, 3 298 spécialistes et 283 dentistes ont offert des services médicaux et de chirurgie dentaire assurés (rémunérés à l'acte).

Le ministère de la Santé a lancé un programme d'embauche et de maintien en poste afin de se pencher sur les problèmes liés à la charge de travail et à la pratique des médecins travaillant dans les régions rurales et éloignées de la Colombie-Britannique. Les modifications apportées à ce programme comprenaient l'élaboration d'un nouveau programme de paiement destiné aux médecins des régions rurales. Par l'entremise du programme d'aide aux déplacements dans le Nord et les régions isolées, des fonds ont été octroyés pour couvrir les coûts de 1 728 visites (d'après les estimations) de médecins de famille et de spécialistes dans 61 collectivités rurales. Le

programme de suppléance dans le Nord et les régions rurales a aidé les médecins pratiquant dans les petites collectivités à recevoir des bourses pour poursuivre leur formation médicale continue et à prendre des vacances.

5.4 Rémunération des médecins

La province de la Colombie-Britannique négocie avec la *British Columbia Medical Association* afin d'établir les modalités, les prestations et les compensations générales à la fois pour les médecins rémunérés à l'acte et pour les médecins rémunérés d'autres façons, notamment les médecins salariés. D'autres professionnels des soins de santé qui offrent des services assurés utilisent des barèmes d'honoraires distincts approuvés par les comités spéciaux compétents.

L'accord entre la *Medical Services Commission*, le gouvernement de la Colombie-Britannique et la *British Colombia Medical Association*, signé en décembre 1993, a été prolongé jusqu'au 31 mars 2001. Il comprend, entre autres éléments clés, un mécanisme d'arbitrage exécutoire et la participation de l'Association et de la Commission.

Au cours de l'exercice 2000-2001, le régime a versé environ 1,62 milliard de dollars aux médecins exerçant dans la province, aux praticiens fournissant des prestations complémentaires et aux gestionnaires des programmes. Pour les services médicaux fournis à l'extérieur de la province, y compris ceux dispensés au Canada et à l'extérieur du pays, le régime a versé environ 35,8 millions de dollars, dont environ 4,5 millions en vertu d'ententes de facturation réciproque avec d'autres provinces ou territoires.

Les services médicaux dispensés dans la province sont payés aux médecins par l'entremise du régime de soins médicaux, d'après la facturation présentée par ceux-ci. Le patient n'intervient habituellement pas dans le processus de paiement. Quatre-vingt-dix-huit pour cent des demandes d'indemnités se font électroniquement par l'entremise du système Teleplan. Le reste est présenté à partir de cartes de demandes d'indemnités par des médecins dont le nombre de patients est moindre et par d'autres professionnels de la santé.

La *Medical Services Commission* finance également certains services médicaux à partir d'autres formules de financement. Une direction générale responsable de ces formules verse des fonds à quelque 360 organismes de soins de santé qui paient des médecins pour dispenser les services approuvés. Environ 1 900 médecins ont volontairement souscrit à ces formules et reçoivent une partie ou la totalité de leur revenu sous forme de salaire, de rémunération à l'acte ou de rémunération à contrat. La possibilité d'établir des honoraires fixés en fonction de la population dans le cas des médecins de famille fait partie des options de paiement présentement prises en considération par le Ministère de la santé.

5.5 Paiements aux hôpitaux

En 2000-2001, le financement total accordé aux instances responsables des services de santé était de 4,8 milliards de dollars, y compris les fonds pour les hôpitaux, les soins prolongés, la promotion de la santé, les services de santé préventifs et les programmes de santé mentale pour adultes. Les paiements aux hôpitaux de l'extérieur de la province, y compris ceux à l'intérieur du Canada et à l'étranger, totalisaient 4,5 millions de dollars pour les services assurés fournis aux habitants de la Colombie-Britannique en 2000-2001.

6.0 Reconnaissance accordé aux transferts fédéraux

Le gouvernement de la Colombie-Britannique a reconnu le financement octroyé par le gouvernement fédéral par l'entremise du Transfert canadien en matière de santé et de programmes sociaux et a produit des rapports à ce propos dans divers sites Web gouvernementaux et documents du gouvernement provincial. Pour l'exercice 2000-2001, ces documents inclus les suivants :

- Comptes publics pour 1999-2000 (déposés en août 2000);
- Comptes publics pour 2000-2001 (déposés en juillet 2001);
- Budget 2001 (déposé en mars 2001);
- Plan sur le rendement du ministère de la Santé et du ministère responsable des personnes âgées pour 2000-2001 (déposé en avril 2000);
- Rapport annuel du ministère de la Santé et du ministère responsable des personnes âgées pour 2000-2001 (déposé en juin 2001).

7.0 Services complémentaires de santé

Regional Programs, du ministère de la Santé, finance une vaste gamme de services communautaires de traitement symptomatique afin de venir en aide aux personnes qui ont des problèmes de santé à long terme entravant leur autonomie ou qui ont besoin de soins actifs pouvant être donnés à domicile. Ces services comprennent : la gestion de cas; les services de soutien à domicile (soutien à domicile, soins infirmiers communautaires à domicile, physiothérapie, ergothérapie, conseils en diététique, services de travailleurs sociaux, repas); les services de soins en établissement (foyers de soins familiaux, foyers de groupe, foyers personnels et foyers de soins intermédiaires et multiniveaux, hôpitaux privés et unités de soins prolongés); les services de soutien spécial (centres de jour pour adultes, services de relève et centres d'évaluation et de traitement). Fournis à l'échelle communautaire, les services sont dispensés par l'intermédiaire des instances responsables des services de santé.

Les services de soins en établissement assurent aux adultes dont on ne peut plus s'occuper à domicile des soins et une surveillance dans un milieu protégé et favorable.

Les services de soins infirmiers communautaires à domicile fournissent des soins infirmiers professionnels aux personnes de tout âge dans leur propre foyer. Ces services sont offerts sur une base non urgente et comprennent l'évaluation, la formation, la consultation, la coordination des soins et les soins infirmiers directs pour les clients ayant besoin de services prolongés, actifs ou palliatifs ou encore, de services de réadaptation.

Les services de soutien à domicile offrent une aide non professionnelle consistant, notamment, en des soins personnels et des services d'entretien ménager. Les centres de jour pour adultes offrent un programme intra-muros d'activités sociales, récréatives et liées à la santé.

Yukon

Aperçu

Les régimes d'assurance-santé du gouvernement du Yukon sont le Régime d'assurance-santé du Yukon (RASY) et le Régime d'assurance-hospitalisation du Yukon (RAHY). Le RASY est administré par un directeur, lequel est nommé par le membre du conseil exécutif (ministre). Le RAHY est géré par un administrateur, lequel est nommé par le commissaire en conseil exécutif (commissaire du Territoire du Yukon). Le directeur du RASY et l'administrateur du RAHY portent ci-après le titre de « directeur des services de santé assurés ». Toute mention du « régime » dans le présent texte concerne soit le RASY ou le RAHY.

L'objectif du système de soins de santé du Yukon est d'assurer l'accès aux services médicaux et hospitaliers assurés, et la transférabilité de ces derniers conformément aux dispositions de la *Loi sur l'assurance-santé* et de la *Loi sur l'assurance-hospitalisation*. La couverture des régimes s'étend à tous les résidents admissibles du Territoire du Yukon. Le ministre de la Santé et des Affaires sociales est responsable de la prestation de tous les services de santé assurés. L'administration de la prestation de ces services est centralisée au ministère de la Santé et des Affaires sociales, Services de santé assurés et Programmes de santé communautaire. Il n'existe aucune instance régionale responsable de la santé. Au 31 mars 2001, le nombre de personnes admissibles inscrites au régime de soins de santé du Yukon s'élevait à 31 133.

D'autres services assurés en vertu de la loi sont offerts aux résidents admissibles du Yukon. Ils comprennent le programme d'assurance-déplacements, le programme de prestations versées aux malades chroniques et aux personnes handicapées, les programmes d'assurance-médicaments et d'assurance-santé complémentaire, et le programme d'assurance-médicaments et de soins de la vue pour les enfants. Le gouvernement du Yukon offre aussi une gamme de programmes non assurés : santé publique, services ambulanciers, soins de l'ouïe, promotion de la santé, santé dentaire et santé mentale.

L'un des principaux défis liés à la prestation des services de santé assurés dans le territoire est l'embauche et le maintien en poste de professionnels de la santé comme les omnipraticiens, les spécialistes et le personnel infirmier. La hausse des coûts attribuable au maintien en poste des professionnels de la santé, à l'administration des hôpitaux, et à l'ajout et au maintien de nouveaux services de diagnostic et de communication de pointe a une incidence directe sur la capacité du gouvernement du Yukon de maintenir ou d'accroître le niveau actuel des services offerts aux résidents admissibles.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

La *Loi sur l'assurance-santé*, adoptée le 1er avril 1972, établit le cadre législatif pour le paiement de services médicaux assurés aux résidents admissibles du Yukon. La *Loi sur l'assurance-hospitalisation*, adoptée le 9 avril 1960, établit le cadre législatif pour le paiement de ces montants aux hôpitaux, en fonction du coût des services assurés qu'ils fournissent aux assurés.

Sous réserve des dispositions de l'article 5 de la *Loi sur l'assurance-santé* et de son règlement, le mandat et la fonction du directeur des services de santé assurés sont :

- d'élaborer et d'administrer le régime;
- de déterminer l'admissibilité aux services de santé assurés;
- d'inscrire des personnes au régime;
- d'effectuer les paiements en vertu du régime, et de décider de l'admissibilité à ces paiements et en fixer les montants;

- de fixer les montants payables pour les services de santé assurés à l'extérieur du Yukon;
- de créer des comités consultatifs et de nommer des particuliers chargés d'aider au fonctionnement du régime;
- d'intenter des poursuites et de négocier des règlements amiables dans l'exercice du droit du gouvernement du Yukon d'être subrogé aux droits des assurés au titre de la présente Loi;
- d'effectuer des enquêtes et des recherches, et d'obtenir des statistiques à ces fins;
- de déterminer les renseignements qui doivent être fournis en application de la présente Loi et les formulaires sur lesquels ils doivent être fournis;
- de nommer des inspecteurs et des vérificateurs pour examiner les dossiers médicaux, rapports et comptes pour en tirer des renseignements;
- de s'acquitter des autres fonctions dont le charge le membre du Conseil exécutif en application de la présente Loi.

Sous réserve des dispositions de l'article 6 de la *Loi sur l'assurance-hospitalisation* et de son règlement, le mandat et la fonction du directeur des services de santé assurés sont :

- de mettre en oeuvre et d'administrer le régime;
- de fixer l'admissibilité et le droit aux services assurés;
- de fixer les montants qui peuvent être versés pour acquitter le coût des services assurés offerts à des bénéficiaires;
- de conclure des accords pour le compte du gouvernement du Yukon avec des hôpitaux, tant à l'intérieur qu'à l'extérieur du Yukon, ou avec le gouvernement du Canada ou d'une province, ou un de leurs organismes compétents, relativement à la fourniture de services assurés à des bénéficiaires;
- d'agréer des hôpitaux pour l'application de la présente Loi;
- d'effectuer des enquêtes, de mener des études et de recueillir des statistiques à ces fins;
- de nommer les inspecteurs et vérificateurs chargés de l'examen et de la cueillette de renseignements dans les livres, rapports et comptes des hôpitaux;
- de prévoir les formules et les livres nécessaires à la mise en oeuvre de la présente Loi;
- d'accomplir toute autre attribution que les règlements peuvent lui attribuer.

Aucune modification n'a été apportée à la législation en 2000-2001.

1.2 Liens hiérarchiques

L'article 6 de la *Loi sur l'assurance-santé* et l'article 7 de la *Loi sur l'assurance-hospitalisation* exigent que le directeur des services de santé assurés présente un rapport annuel au membre du Conseil exécutif relativement à l'administration des deux régimes d'assurance-santé. L'état des recettes et dépenses est déposé devant l'assemblée législative et doit faire l'objet de discussions.

L'état des recettes et des dépenses pour les programmes d'assurance-santé de la Direction des services de santé est déposé tous les ans durant la séance d'automne de l'assemblée législative. Le rapport déposé en décembre 2001 couvrait les exercices 1998-1999, 1999-2000 et 2000-2001.

1.3 Vérification des comptes

Le Régime d'assurance-santé et le Régime d'assurance-hospitalisation sont vérifiés par le bureau du vérificateur général. Le vérificateur général du Canada agit à titre de vérificateur du gouvernement du Yukon, conformément à l'article 30 de la *Loi sur le Yukon* (Canada) et l'alinéa 8(4)e) de la *Loi sur la gestion des finances publiques* (Yukon). Le vérificateur général doit mener une vérification annuelle des transactions et des états financiers consolidés du gouvernement. La vérification la plus récente concernait l'exercice se terminant le 31 mars 2001.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les articles 3, 4, 5 et 9 de la *Loi sur l'assurance-hospitalisation* et les articles 2, 4, 5, 9 et 11 du Règlement sur l'assurance-hospitalisation du Yukon prévoient la prestation de services hospitaliers assurés. Aucune modification n'a été apportée à la législation en 2000-2001.

En 2000-2001, 15 établissements situés sur l'ensemble du territoire ont dispensé des services hospitaliers assurés aux malades hospitalisés et externes. Ces établissements comprennent un hôpital général, un hôpital pavillonnaire[1] et douze centres de santé[2]. Des services de soins infirmiers sont offerts périodiquement dans un poste sanitaire[3].

Tous les services dispensés dans un hôpital par le personnel hospitalier sont assurés. Tout nouveau programme ou toute nouvelle amélioration nécessitant d'importantes ressources financières, ou la réduction de services ou de programmes doivent être autorisés au préalable par le ministre de la Santé et des Affaires sociales.

En vertu des alinéas e) et f) de l'article 2 du Règlement sur l'assurance-hospitalisation du Yukon, les services rendus dans un hôpital agréé sont assurés. La définition des « services assurés aux patients hospitalisés » qui figure à l'alinéa e) de l'article 2 inclut tous les services suivants fournis aux malades hospitalisés, à savoir :

- l'hébergement et les repas correspondant à ceux en salle commune ou au service normale;
- les services infirmiers essentiels;
- les examens de laboratoire, radiographies et épreuves diagnostiques ainsi que l'interprétation de leurs résultats dans le but de préserver la santé, de prévenir la maladie ou de faciliter le diagnostic et le traitement d'un traumatisme, d'une maladie ou d'un handicap;
- les médicaments, les produits biologiques et les préparations connexes indiqués à l'annexe B du Règlement, lorsqu'ils sont fournis par l'hôpital;
- l'usage de la salle d'opération, de la salle d'examen et des installations d'anesthésie, y compris du matériel et des fournitures connexes;
- les fournitures chirurgicales habituelles;
- l'usage des installations de radiothérapie, s'il y a lieu;
- l'usage des installations de physiothérapie, s'il y a lieu;
- les services rendus par des personnes touchant une rémunération de l'hôpital.

La définition des « services assurés aux malades externes » qui figure à l'alinéa f) de l'article 2 du même Règlement inclut les services fournis aux malades externes pour le diagnostic ou le traitement d'urgence dans les 24 heures suivant un accident (laquelle période peut être prolongée par l'administrateur lorsque le service n'a pu être obtenu dans les 24 heures suivant l'accident), à savoir :

- les services infirmiers essentiels;
- les examens de laboratoire, radiographies et autres épreuves diagnostiques ainsi que l'interprétation de leurs résultats dans le but de faciliter le diagnostic et de soigner un traumatisme;
- les médicaments, produits biologiques et préparations connexes indiqués à l'annexe B du présent Règlement lorsqu'ils sont fournis à l'hôpital;
- l'usage de la salle d'opération et des installations d'anesthésie, y compris du matériel et des fournitures connexes;
- les fournitures chirurgicales habituelles;

[1] Établissement qui dispense des soins d'urgence, des services d'hospitalisation de courte durée et des services de relève 24 heures sur 24.

[2] Des infirmières communautaires voient, en l'absence d'un médecin, à la prestation de services cliniques de jour (soins médicaux), à l'exécution de programmes de santé communautaire et à la prestation de services d'urgence 24 heures sur 24.

[3] Établissement qui sert de clinique où des infirmières communautaires fournissent des services selon un horaire régulier.

- les services rendus par des personnes touchant une rémunération de l'hôpital;
- l'usage des installations de radiothérapie, s'il y a lieu;
- l'usage des installations de physiothérapie, s'il y a lieu.

2.2 Services médicaux assurés

Les articles 1 à 8 de la *Loi sur l'assurance-santé*, adoptée le 1er avril 1972, et les articles 2, 3, 4, 7,10 et 13 du Règlement sur le Régime d'assurance-santé du Yukon prévoient la prestation de services médicaux assurés. Aucune modification n'a été apportée à la législation en 2000-2001.

Le Régime d'assurance-santé du Yukon couvre les services médicalement nécessaires fournis par des médecins. Un médecin qui désire participer au Régime d'assurance-santé du Yukon doit satisfaire aux exigences suivantes :

- déposer une demande de permis, conformément à la *Loi sur la profession médicale*;
- maintenir son permis, conformément à la *Loi sur la profession médicale*.

Aux termes du paragraphe 7(5) du Règlement sur le Régime d'assurance-santé du Yukon « s'il le désire, le médecin peut percevoir les honoraires approuvés pour les services rendus de l'assuré, sans passer directement par le Régime sans que l'assuré en soit pénalisé en faisant part de son choix par écrit au Directeur ». En 2000-2001, aucun médecin n'a choisi de toucher ses honoraires autrement que par l'entremise du Régime d'assurance-santé du Yukon.

Les services médicaux assurés au Yukon sont définis comme des services médicalement nécessaires rendus par un médecin. Une liste des services non assurés par le régime figure à l'article 3 du Règlement sur le Régime d'assurance-santé du Yukon (voir la section 2.4). Les services non couverts par le régime comprennent les suivants : consultations téléphoniques, services médicaux-légaux, préparation de dossiers et de rapports, services rendus à la demande d'un tiers, services fournis à des fins esthétiques et services désignés comme non médicalement nécessaires.

Durant la période débutant le 1er avril 2000 et se terminant le 31 mars 2001, les services suivants ont été ajoutés à la liste des services médicaux couverts par le Régime d'assurance-santé du Yukon :

- gestion d'une deuxième période de l'accouchement prolongée (code de rémunération 4199);
- réparation d'une séparation complète du sphincter externe (code de rémunération 4022);
- réparation de lacérations graves du vagin ou du col utérin (code de rémunération 4023);
- consultation en rhumatologie (code de rémunération 3101);
- consultation supplémentaire en rhumatologie - nombre limité (code de rémunération 3102);
- consultation en rhumatologie au cabinet (code de rémunération 3101).

La procédure suivie au Yukon pour ajouter un service médical à la liste des services assurés couverts par le Régime d'assurance-santé du Yukon exige que les médecins déposent une demande par écrit pour faire ajouter un code de rémunération au *Relative Value Guide to Fees*[4] (Guide de la valeur relative des honoraires). La demande est ensuite examinée par le comité de liaison de L'Association médicale du Yukon et du Régime d'assurance-santé du Yukon. À la suite de cet examen, une décision est rendue concernant l'inclusion ou l'exclusion du service. Les coûts ou les honoraires sont normalement établis en fonction des coûts ou honoraires payés dans d'autres administrations. Une fois que la valeur de la rémunération pour un service particulier a été fixée, tous les médecins du Yukon en sont informés. Aucune consultation publique n'est nécessaire dans le cadre de cette procédure.

[4] Guide de la rémunération des médecins.

2.3 Services de chirurgie dentaire assurés

Les dentistes qui fournissent des services de chirurgie dentaire assurés en vertu du Régime d'assurance-santé du Yukon doivent être autorisés à exercer en vertu de la *Loi sur les professions dentaires* et possèdent des numéros à inscrire sur les factures qu'ils présentent au Régime d'assurance-santé du Yukon pour la prestation de services dentaires assurés. En 2000-2001, six dentistes, trois chirurgiens stomatologistes et deux orthodontistes faisaient parvenir leurs factures au régime pour des services dentaires assurés. Aucun dentiste ne s'est retiré du Régime d'assurance-santé du Yukon en 2000-2001.

Les services dentaires assurés sont limités aux actes de chirurgie dentaire inscrits en annexe du Règlement et qui ne peuvent être exécutés que dans un hôpital en raison des ressources uniques qu'ils exigent. C'est le cas, par exemple, de la correction chirurgicale du prognathisme ou de la micrognathie. Les services dentaires assurés comprennent :

- l'extraction chirurgicale de dents à éruption incomplète;
- l'alvéoloplastie et la gingivoplastie;
- l'approfondissement du sillon et le remodelage de la crête alvéolaire;
- l'exposition des dents pour les besoins de traitements orthodontiques;
- le traitement de blessures accidentelles aux tissus mous de la bouche;
- la résection d'une racine;
- la phrénicectomie;
- l'excision de kystes intra-oraux;
- l'excision de tumeurs bénignes intra-orales;
- la sialolithotomie;
- l'excision de grenouillettes sublinguales;
- la condylectomie;
- la biopsie intra-orale;
- l'incision et le drainage d'un abcès d'origine dentaire;
- la réduction orthopédique de fractures de la mandibule et du maxillaire;
- la réduction chirurgicale de fractures de la mandibule et du maxillaire;
- la réduction orthopédique d'une dislocation temporo-mandibulaire;
- la réduction chirurgicale d'une dislocation temporo-mandibulaire;
- l'extraction d'une racine ou d'un corps étranger du sinus maxillaire;
- la réparation et la fermeture d'une fistule bucco-sinusale;
- la correction chirurgicale du prognathisme ou de la micrognathie;
- l'alcoolisation d'une branche nerveuse aux fins de diagnostic ou de thérapie;
- l'avulsion d'un nerf (mentonnier, infra-orbital ou dentaire inférieur).

Dans le cas des enfants de 16 ans ou moins, les services de chirurgie dentaire suivants sont aussi assurés :

- chirurgie buccale et orthodontie nécessaire à la réparation d'une fente palatine ou d'une fissure labiale ou y faisant suite, seulement lorsque ce service s'inscrit dans le cadre d'une chirurgie plastique réparatrice ou y fait suite;
- extraction chirurgicale de dents à éruption complétée ou incomplète ou, encore, d'une dent incluse;
- tous les autres soins dentaires désignés comme médicalement nécessaires par le directeur des services de santé assurés.

L'ajout de nouveaux services de chirurgie dentaire à la liste des services assurés exige l'apport d'une modification établie par décret à l'annexe B du Règlement concernant les services d'assurance-santé.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Seuls les services prescrits et rendus conformément à la *Loi sur l'assurance-santé* et son règlement et à la *Loi sur l'assurance-hospitalisation* et son règlement sont assurés. Aucun autre service n'est couvert. Une liste complète de ces services figure dans les documents supplémentaires.

Les services médicaux non assurés comprennent les suivants :

- les services non médicalement nécessaires;
- les frais d'interurbains;
- la préparation ou la fourniture d'un médicament;
- les conférences au sujet d'un cas;
- les consultations téléphoniques à la demande de la personne assurée;
- les services médico-légaux, y compris les examens et les rapports;
- les services fournis à des fins esthétiques;
- l'acuponcture;
- les interventions expérimentales.

L'article 3 du Règlement sur le Régime d'assurance-santé du Yukon renferme une liste partielle des services non assurés.

Les services hospitaliers non assurés comprennent l'hospitalisation des non-résidents; le supplément pour une chambre privée ou semi-privée lorsque celle-ci n'est pas médicalement nécessaire; les services infirmiers privés; la télévision; le téléphone; les médicaments et les produits biologiques requis par un malade après son congé de l'hôpital. (Ces services ne sont pas fournis par l'hôpital.)

Les services dentaires restaurateurs ne sont pas assurés.

Tous les résidents du Yukon jouissent de l'égalité d'accès aux services. Les tiers, comme les assureurs privés et la Commission de la santé et de la sécurité au travail, n'ont pas accès en priorité aux services. Le territoire n'a aucun processus officiel en place pour surveiller la conformité; toutefois, les commentaires des médecins, des administrateurs d'hôpitaux, des professionnels de la santé et du personnel permettent au directeur des services de santé assurés de se tenir au courant des préoccupations relatives à l'usage et aux services.

L'achat de services ou de fournitures non assurés, comme les plâtres en fibre de verre, ne compromet en rien l'accès aux services assurés. Les assurés sont informés de leurs options en matière de traitement lorsqu'ils reçoivent le service. Le territoire n'a aucun processus officiel en place pour surveiller la conformité; toutefois, les commentaires des médecins, des administrateurs d'hôpitaux, des professionnels de la santé et du personnel permettent au directeur des services de santé assurés de se tenir au courant des préoccupations relatives à l'usage et aux services.

Le processus utilisé pour désassurer un service couvert par le Régime d'assurance-santé du Yukon est le suivant :

- **Services médicaux** : Le Comité de liaison de l'Association médicale du Yukon et du Régime d'assurance-santé du Yukon examine les modifications à apporter au *Relative Value Guide to Fees* (guide de la valeur relative des honoraires), notamment les décisions consistant à retirer certains services. En collaboration avec le conseiller médical du Yukon, le comité prend une décision en se fondant sur des preuves médicales indiquant que le service est inefficace ou pose un risque potentiel à la santé des malades. Une fois la décision prise de désassurer un service, tous les médecins en sont avisés par écrit. Le directeur des services de santé assurés gère ce processus.
- **Services hospitaliers** : Il est nécessaire qu'une modification établie par décret soit apportée aux alinéas e) et f) de l'article 2 du Règlement sur l'assurance-hospitalisation du Yukon. Au 31 mars 2001, aucun service hospitalier fourni aux malades hospitalisés ou externes, en vertu du règlement, n'a été retiré. Le directeur des services de santé assurés gère le processus en collaboration avec la *Yukon Hospital Corporation*.
- **Services de chirurgie dentaire** : Il est nécessaire qu'une modification établie par décret soit apportée à l'annexe B du Règlement concernant les services d'assurance-santé.

En 2000-2001, aucun service n'a été supprimé du *Relative Value Guide to Fees*.

3.0 Universalité

3.1 Admissibilité au régime

Les conditions et les exigences régissant l'admissibilité aux services hospitaliers assurés sont énoncées à l'article 2 de la *Loi sur l'assurance-santé*, à l'article 4 de la *Loi sur l'assurance-santé* et de son règlement, à l'article 2 de la *Loi sur l'assurance-hospitalisation*, et à l'article 4 de la *Loi sur l'assurance-hospitalisation* et de son règlement. Sous réserve des dispositions de ces lois et de leurs règlements, tous les résidents du Yukon sont admissibles à des services de santé assurés et y ont droit en vertu de modalités uniformes. La définition du mot « résident » est celle qui est utilisée dans la *Loi canadienne sur la santé* : « personne légalement autorisée à être ou à rester au Canada, qui est domiciliée et qui réside habituellement au Yukon, à l'exception d'une personne faisant du tourisme, de passage ou en visite au Yukon ».

En vertu du paragraphe 4.(1) des deux règlements sur les soins d'assurance-santé « un assuré est admissible aux services assurés et y a droit après minuit, le dernier jour du second mois suivant son arrivée au Yukon ».

Les résidents qui ne sont pas admissibles à une couverture sont ceux qui ont droit à des prestations ou qui y sont admissibles en vertu de toute autre loi du Yukon, d'une loi d'une province, ou d'une loi du Parlement du Canada autre que la *Loi canadienne sur la santé*. Cette définition inclut, sans s'y limiter, les membres des Forces canadiennes, les membres de la Gendarmerie royale du Canada (GRC) et les détenus des pénitenciers fédéraux.

Les personnes qui fournissent un document indiquant la date de congé ou de libération de la GRC, des forces armées ou d'un pénitencier fédéral deviennent admissibles à la couverture du Régime d'assurance-santé du Yukon le lendemain de la date indiquée sur le document.

3.2 Exigences relatives à l'inscription au régime

On conseille aux personnes qui s'installent dans le territoire de présenter une demande d'inscription au Régime d'assurance-santé du Yukon dès leur arrivée. Pour ce faire, elles doivent remplir une formule d'inscription disponible dans les bureaux des services de santé assurés ou auprès des agents territoriaux de la communauté. Une fois la demande approuvée, une carte de santé est envoyée par la poste au demandeur. Chaque membre de la famille reçoit une carte de santé et un numéro de santé distincts. La couverture expire chaque année, à la date d'anniversaire du résident, et une étiquette de mise à jour affichant une nouvelle date d'expiration est envoyée par la poste tous les ans.

Si d'autres membres de la famille arrivent au Yukon en devançant l'un des conjoints résidant ailleurs au Canada, la province ou le territoire d'origine assurera la couverture de tous les membres de la famille durant une période maximale de 12 mois, conformément à l'Accord interprovincial-territorial sur l'admissibilité et la transférabilité.

Au 31 mars 2001, 31 133 personnes étaient inscrites au Régime d'assurance-santé du Yukon.

Aux termes de l'article 16 de la *Loi sur l'assurance-santé*, « Chaque résident, sauf les personnes à charge ou celles qui sont exemptées par les règlements, est tenu de s'inscrire lui-même et d'inscrire les personnes à sa charge auprès du directeur des services de santé assurés selon les modalités — de forme et de temps — réglementaires. »

3.3 Autres catégories de personnes assurées

Les conditions concernant l'admissibilité à la couverture s'appliquant à des catégories spéciales de personnes sont les suivantes :

- Canadiens qui reviennent dans le territoire et immigrants reçus : aucune période d'attente paragraphe 4(3) du Règlement sur le Régime d'assurance-santé du Yukon et 4(3)

du Règlement sur l'assurance-hospitalisation du Yukon);

- permis de travail ministériel : aucune période d'attente pour les personnes admissibles;
- réfugiés au sens de la Convention : admissibles s'ils détiennent un permis de travail valable pour une période d'un an;
- résidents temporaires autorisés (p. ex., permis de travail et permis autres que les permis ministériels) : aucune période d'attente.

Quatre détenteurs de permis de travail résidaient au Yukon au 31 mars 2001.

3.4 Primes

Les résidents du Yukon ne paient aucune prime.

4.0 Transférabilité

4.1 Délai minimal de résidence

Les personnes en provenance d'une autre région du Canada qui s'installent au Yukon ont droit à la couverture en vertu du paragraphe 4.(1) du Règlement sur le Régime d'assurance-santé du Yukon et du Règlement sur l'assurance-hospitalisation du Yukon. Aux termes du paragraphe 4.(1), « un bénéficiaire est admissible aux services assurés à compter de minuit, le dernier jour du deuxième mois suivant le mois de son arrivée au Yukon ».

4.2 Couverture durant des absences temporaires (au Canada)

Les dispositions relatives à la transférabilité de l'assurance-santé pendant les absences temporaires au Canada sont énoncées dans les articles 5, 6, 7 et 10 du Règlement sur le Régime d'assurance-santé du Yukon et l'article 6, les paragraphes (1) et (2) de l'article 7 et l'article 9 du Règlement sur l'assurance-hospitalisation du Yukon.

Ces deux règlements stipulent que lorsqu'un assuré s'absente du territoire avec l'intention d'y revenir, il a le droit de recevoir des services assurés durant une absence de 12 mois consécutifs.

Les étudiants qui fréquentent un établissement d'enseignement situé à l'extérieur du territoire demeurent admissibles à l'assurance-santé pendant la durée de leurs études (ils doivent envoyer chaque année une confirmation de leur inscription). Le directeur des services de santé assurés peut accorder une protection pour d'autres types d'absences supérieures à 12 mois consécutifs, moyennant la présentation d'une demande écrite par l'assuré. Les demandes de prolongation doivent être examinées chaque année et être approuvées par le directeur des services de santé assurés. En ce qui concerne les travailleurs temporaires, le directeur des services de santé assurés peut accorder une protection malgré une absence de plus de 12 mois consécutifs sur présentation d'une demande écrite par l'assuré. En ce qui concerne les missionnaires, le directeur des services de santé assurés peut accorder une protection pour une absence de plus de 12 mois consécutifs sur présentation d'une demande écrite par l'assuré. Les demandes de prolongation doivent être renouvelées chaque année et être approuvées par le directeur des services de santé assurés.

Les dispositions relatives à la protection pendant des séjours temporaires au Canada sont conformes aux modalités de l'Accord interprovincial-territorial sur l'admissibilité et la transférabilité qui est entré en vigueur le 1er janvier 1998. Les définitions ont été uniformisées dans le règlement d'application, les politiques et les procédures.

Le Yukon adhère complètement aux ententes interprovinciales et interterritoriales sur la facturation réciproque pour les services médicaux et hospitaliers, conclues avec les autres provinces et territoires (le Québec ne participe pas aux ententes de facturation réciproque pour les services médicaux). Les services assurés fournis aux résidents du Yukon temporairement absents du territoire sont payés aux taux établis par la province d'accueil. Les montants suivants ont été

versés à des hôpitaux de l'extérieur du territoire en 2000-2001.

Services aux malades hospitalisés	Services aux malades externes
4 220 525 $	857 580 $

Nota : Ces statistiques sont compilés d'après la date de prestation des services et ne sont pas définitives.

En 2000-2001, les réclamations payées pour des services médicaux dispensés hors territoire totalisaient 1 660 572 $. (Nota : Ce montant inclut les coûts des services dispensés à l'étranger et est calculé en fonction de la date de paiement.)

Le paiement des services hospitaliers assurés fournis à l'extérieur du territoire à des malades externes ou hospitalisés résidents du Yukon et admissibles est accordé en vertu des ententes de facturation réciproque pour les services hospitaliers. Les coûts élevés de certains actes médicaux, les frais pour les accouchements et le coût des consultations externes sont déterminés par le Comité fédéral-provincial-territorial de coordination de la facturation réciproque. Ces taux ont été établis par décret, conformément au Règlement sur la facturation des soins dispensés en consultation externe, au Règlement sur le taux normalisé pour un traitement en clinique et au Règlement sur la facturation des traitements coûteux aux malades hospitalisés.

Le paiement des services médicaux assurés fournis à l'extérieur du territoire aux résidents du Yukon admissibles est accordé en vertu des ententes de facturation réciproque. Le paiement est versé à la province d'accueil aux taux établis par cette dernière.

4.3 Couverture durant des absences temporaires (à l'étranger)

Les dispositions relatives à la transférabilité de l'assurance-santé pendant les séjours temporaires à l'étranger sont énoncées aux articles 5, 6, 7, 9, 10 et 11 du Règlement sur le Régime d'assurance-santé du Yukon, et aux articles 6, 7(1) et (2), et 9 du Règlement sur l'assurance-hospitalisation du Yukon.

En vertu des articles 5 et 6, un assuré qui est absent du territoire et qui a l'intention d'y revenir est admissible aux services assurés pendant une période de 12 mois consécutifs.

Les dispositions concernant la transférabilité de l'assurance-santé en cas de séjours à l'étranger sont semblables à celles en vigueur pour les séjours au Canada (voir la section 4.2). Des dispositions similaires s'appliquent aux étudiants, aux travailleurs temporaires et aux missionnaires à l'étranger.

Les étudiants qui fréquentent un établissement d'enseignement situé à l'extérieur du territoire demeurent admissibles pendant toute la durée de leurs études (ils doivent envoyer chaque année une confirmation de leur inscription). En ce qui concerne les travailleurs temporaires, le directeur des services de santé assurés peut accorder une protection pour une absence de plus de 12 mois consécutifs sur présentation d'une demande écrite par l'assuré. En ce qui concerne les missionnaires, le directeur des services de santé assurés peut accorder une protection pour une absence de plus de 12 mois consécutifs sur présentation d'une demande écrite par l'assuré. Toutes les demandes de prolongement doivent être renouvelées chaque année et sont sujettes à l'approbation du directeur des services de santé assurés.

Les services médicaux assurés fournis à l'étranger aux résidents admissibles du Yukon qui sont temporairement à l'extérieur du pays sont remboursés aux taux équivalents à ceux du Yukon. En vertu du Régime d'assurance-santé du Yukon, la somme est versée à l'assuré ou directement au fournisseur du service assuré.

Les services hospitaliers assurés fournis à l'extérieur au Canada aux malades hospitalisés admissibles résidant au Yukon sont payés aux taux établis par le Règlement sur le taux normalisé pour un traitement en clinique pour l'Hôpital général de Whitehorse. Les services facultatifs ou d'urgence sont remboursés. Des exceptions peuvent être faites quand les services dispensés à l'extérieur du territoire ne sont pas offerts au Canada. Le paiement est fondé sur le taux standard approuvé de l'établissement autorisé canadien le plus près fournissant un service de nature semblable.

Une autorisation préalable est requise. Le taux normalisé de l'Hôpital général de Whitehorse était, au 31 mars 2001, de 989 $ pour une hospitalisation en salle commune. Ce taux, établi par décret, est obtenu de la façon suivante :

- taux normalisé en salle commune = (total des frais d'exploitation - coûts d'hospitalisation non liés aux malades - coûts des naissances - coûts des services fournis aux malades externes) / (total des jours-patients - jours-patients pour les autres services (p. ex., aux non-Canadiens).

Les services hospitaliers assurés fournis à l'extérieur du Canada aux malades externes admissibles du Yukon sont remboursés au taux établi par le Règlement sur la facturation des soins dispensés en consultation externe. Ce taux, qui est actuellement de 110 $, est établi par décret et a été fixé par le Comité fédéral-provincial-territorial de coordination de la facturation réciproque.

Les montants suivants ont été remboursés pour les services facultatifs et d'urgence fournis à l'étranger aux résidents du Yukon admissibles :

Services aux malades hospitalisés	Services aux malades externes
20 597 $	8 368$

Nota : Ces statistiques sont compilées d'après la date de prestation de services et ne sont pas définitives.

Aucune exigence législative n'oblige les résidents admissibles à obtenir une autorisation avant de recevoir des services facultatifs ou d'urgence à l'étranger.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Le Régime d'assurance-santé du Yukon et le Régime d'assurance-hospitalisation du Yukon ne prévoient aucuns frais modérateurs ou de coassurance. Les services spécialisés et les autres services qui ne sont pas offerts localement sont assurés par l'entremise d'un médecin spécialiste itinérant et d'un programme public d'assurance-déplacements. Aucun service assuré en vertu du régime d'assurance-santé fourni au Yukon ne fait l'objet de surfacturation.

5.2 Accès aux services hospitaliers assurés

Il n'y a pas de pénurie de lits d'hôpitaux et il n'existe aucune liste d'attente pour l'admission à l'hôpital. Le principal établissement de soins actifs du Yukon est l'Hôpital général de Whitehorse. Au 31 mars 2001, cet établissement comptait 49 lits dotés en personnel et il reste suffisamment d'espace pour ouvrir huit lits supplémentaires pour soins actifs si jamais les tendances d'occupation en indiquent le besoin. Le Yukon ne dispose pas de lits de réadaptation; les malades sont envoyés à l'extérieur du territoire pour recevoir ces services, généralement à Vancouver ou à Edmonton.

L'Hôpital général de Whitehorse emploie actuellement 103 infirmières et infirmiers, ce qui équivaut à 72 ¾ postes d'équivalent à temps plein (ETP). Un personnel complet compte 75 ¾ ETP.

L'Hôpital général de Whitehorse offre des services aux malades hospitalisés et aux malades externes ainsi des services d'urgence 24 heures sur 24. Les services d'urgence sont offerts en rotation par les médecins locaux. Les services médicaux comprennent :

- les soins intensifs (soins chirurgicaux et cardiaques);
- le traitement des problèmes respiratoires (bronchopneumopathie chronique obstructive [bpco], asthme, etc.);
- le traitement des accidents cardiovasculaires;
- les services d'obstétrique;
- le traitement des saignements gastrointestinaux;
- le traitement de la cellulite;
- la chimiothérapie;
- le traitement de l'hypertension;

- le traitement de l'impossibilité de faire des efforts et de la faiblesse.

L'Hôpital général de Whitehorse offre aussi des services chirurgicaux dans les domaines suivants :

- soins orthopédiques mineurs;
- gynécologie;
- pédiatrie;
- troubles gastriques généraux;
- mastectomie;
- trauma (urgence);
- oto-rhino-laryngologie;
- ophtalmologie, y compris la chirurgie de la cataracte.

Les malades qui ont besoin de chirurgies spécialisées sont envoyés dans des centres externes.

Les services de diagnostic comprennent :

- la radiologie;
- les analyses de laboratoire;
- les mammographies;
- les électrocardiogrammes.

Les services de réadaptation sont limités.

Il n'y a pas de liste d'attente pour être admis à l'Hôpital général de Whitehorse. Les malades qui ont besoin de toute urgence d'une chirurgie d'un jour sont généralement opérés en moins de 24 heures. Les chirurgies d'un jour et les chirurgies courantes non urgentes sont généralement effectuées en moins de deux semaines. Le nombre de consultations de spécialistes itinérants est augmenté régulièrement, ce qui permet de réduire les périodes d'attente, en particulier en orthopédie, en oto-rhino-laryngologie et en ophtalmologie (voir la section 5.3). Pour ce qui est des services qui ne sont pas offerts dans la collectivité, le programme de médecins spécialistes itinérants et le programme d'assurance-déplacements aident les personnes admissibles à assumer le coût du transport d'urgence médicalement nécessaire et des services assurés non urgents.

Le Yukon compte un autre établissement de soins actifs, l'Hôpital Watson Lake Cottage. Cet établissement compte 12 lits et il n'y a pas de liste d'attente.

À part l'Hôpital général de Whitehorse et l'Hôpital Watson Lake Cottage, seul le Dawson Health Centre offre des services aux malades hospitalisés, et ces services sont restreints. Les 12 centres de santé communautaire fournissent des services aux malades externes et des services d'urgence 24 heures sur 24. Les centres de santé sont dotés de personnel infirmier et auxiliaire. Les communautés de Whitehorse, Faro, Mayo, Watson Lake et Dawson City ont des médecins résidents.

En avril 1998, le ministère de la Santé et des Affaires sociales et le ministère des Services gouvernementaux du Yukon, en collaboration avec NorthwesTel, ont reçu du financement du Réseau canadien pour l'avancement de la recherche, de l'industrie et de l'enseignement (Canarie) pour un projet pilote de télémédecine à Dawson City, Ross River et Teslin. Ce projet avait pour but de permettre au Ministère de vérifier si la télémédecine améliore l'accès aux services médicaux et, par conséquent, si elle accroît la qualité des soins. Le projet pilote a débuté en juillet 1998 et s'est terminé le 30 juin 1999.

Compte tenu du succès remporté par le projet de télémédecine en 1998, une demande a été présentée au Programme des partenariats pour l'infostructure canadienne de la santé (PPICS) pour l'utilisation de la vidéo en temps réel pour faciliter l'accès aux services et leur prestation entre les régions périphériques rurales et Whitehorse et entre Whitehorse et des centres situés en Colombie-Britannique et en Alberta. Le PPICS a récemment approuvé un financement de un million de dollars pour ce projet, qui sera réalisé entre le 1er septembre 2001 et le 31 mars 2003.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Le tableau suivant est une ventilation du nombre de médecins résidents, de spécialistes et de dentistes qui fournissaient des services au Yukon au 31 mars 2001 :

Omnipraticiens, médecins de famille	43
Spécialistes	6
Dentistes	11

Le tableau suivant est une ventilation du nombre de spécialistes qui fournissent des services dans le cadre du programme de médecins spécialistes itinérants :

Ophtalmologie	1
Oncologie	3
Orthopédie	4
Médecine interne	1
Oto-rhino-laryngologie	2
Neurologie	1
Rhumatologie	1
Dermatologie	1
Chirurgie dentaire	1
Maladies infectieuses	1
Pédopsychiatrie	1

Les consultations des spécialistes itinérants se tiennent de une à huit fois par année, selon la demande de services et la disponibilité des spécialistes. Au 31 mars 2001, les périodes d'attente pour des services spécialisés non urgents étaient estimées comme suit :

Ophtalmologie	de 0 à 6 mois
Orthopédie	de 6 à 12 mois
Oto-rhino-laryngologie	de 8 à 10 mois
Chirurgie dentaire	de 2 à 3 mois

La plupart des médecins du Yukon se trouvent à Whitehorse. À l'extérieur de Whitehorse, seules deux collectivités rurales ont des médecins résidents rémunérés à l'acte : Dawson City et Watson Lake. Deux autres médecins contractuels desservent les collectivités de Faro et de Mayo.

Un programme de médecins itinérants offre l'accès à des services médicaux assurés à 10 collectivités rurales et éloignées. La fréquence des consultations itinérantes est fonction de la demande et de l'utilisation. Les médecins qui fournissent des services itinérants sont indemnisés pour le temps de pratique perdu, le kilométrage, les repas et l'hébergement.

Le programme d'assurance-déplacements aide les résidents admissibles à assumer le coût du transport médicalement nécessaire à partir d'une région rurale pour accéder aux services médicaux et hospitaliers qui ne sont pas disponibles localement.

Le ministère de la Santé et des Affaires sociales et l'Association médicale du Yukon discutent actuellement de stratégies qui permettront de combler les besoins actuels en médecins et en médecins suppléants au Yukon. Plusieurs options sont à l'étude.

5.4 Rémunération des médecins

Le ministère de la Santé et des Affaires sociales obtient son mandat du gouvernement du Yukon avant de négocier avec l'Association médicale du Yukon (AMY). L'AMY et le gouvernement nomment chacun des membres de l'équipe de négociation. Ces derniers se réunissent jusqu'à ce qu'ils en arrivent à un accord. L'équipe de négociation de l'AMY demande aux membres de l'AMY d'approuver le projet d'entente. Le ministère de la Santé et des Affaires sociales demande au gouvernement du Yukon de ratifier l'entente. L'entente finale est signée avec l'assentiment des deux parties.

Les plus récentes négociations se sont terminées le 14 décembre 1999. Le protocole d'entente qui en a résulté est entré en vigueur le 1er avril 1999 et se terminera le 31 mars 2002.

La *Loi sur l'assurance-santé* et le Règlement sur le Régime d'assurance-santé du Yukon régissent le paiement des services médicaux et de chirurgie dentaire assurés.

La majeure partie des services médicaux et de chirurgie dentaire assurés fournis aux résidents est remboursée en fonction du système de rémunération à l'acte. À l'heure actuelle, deux médecins pratiquant à temps plein en région

rurale sont rémunérés sur une base contractuelle, et un médecin qui offre des consultations dans une région périphérique est rémunéré à taux fixe pour chaque séance.

5.5 Paiements aux hôpitaux

Le gouvernement du Yukon finance la *Yukon Hospital Corporation* (l'Hôpital général de Whitehorse) par l'entremise d'accords de contribution globaux conclus avec le ministère de la Santé et des Affaires sociales. Les niveaux de financement globaux des frais de fonctionnement et d'entretien et des immobilisations sont établis en fonction des exigences opérationnelles et des projections fondées sur les années antérieures. L'accord de contribution d'un an est en vigueur jusqu'au 31 mars 2002.

En plus du financement des frais de fonctionnement et d'entretien et des immobilisations prévu par l'accord, les hôpitaux peuvent présenter des demandes de financement supplémentaire pour mettre en œuvre des programmes nouveaux ou améliorés.

Seul l'Hôpital général de Whitehorse reçoit des fonds dans le cadre d'accords de contribution. L'hôpital pavillonnaire et tous les centres de santé sont financés à partir du budget du gouvernement du Yukon.

La *Loi sur l'assurance-hospitalisation* et le Règlement sur l'assurance-hospitalisation du Yukon régissent les paiements versés par le régime d'assurance-santé aux établissements qui offrent des services hospitaliers assurés. Cette réglementation établit le cadre législatif régissant le versement de montants correspondant aux coûts des services assurés fournis par ces hôpitaux aux assurés.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement du territoire du Yukon a tenu compte des contributions fédérales versées dans le cadre du Transfert canadien en matière de santé et de programmes sociaux dans son Budget annuel des dépenses pour 2000-2001 et dans la publication de ses comptes publics, lesquels peuvent être consultés par les résidents du Yukon.

7.0 Services complémentaires de santé

Des services complémentaires de santé sont offerts aux résidents admissibles du Yukon. En 2000-2001, le Yukon a fourni les services complémentaires de santé suivants :

- soins intermédiaires en maison de repos;
- soins en établissement pour adultes;
- soins à domicile;
- soins ambulatoires.

Les paragraphes qui suivent décrivent les types de services fournis par établissement ou programme.

MacDonald Lodge

- Soins en établissement pour adultes
- Soins à domicile

Macaulay Lodge

- Soins intermédiaires en maison de repos
- Soins à domicile

Thompson Centre

- Soins intermédiaires en maison de repos
- Soins ambulatoires
- Soins à domicile

Programme de soins à domicile du Yukon :

- Soins à domicile
- Soins ambulatoires

Aucun changement important n'a été apporté à la gestion de ces services en 2000-2001.

Les résidents admissibles du Yukon ont aussi accès aux programmes et services suivants :

Programme de prestations versées aux malades chroniques et aux personnes handicapées – Verse des prestations aux résidents du Yukon atteints d'une maladie chronique particulière ou d'un grave handicap fonctionnel. Couvre des médicaments d'ordonnance et les fournitures et pièces d'équipement médicochirurgicales nécessaires. (*Chronic Disease and Disability Benefits Regulation)*

Programme d'assurance-médicaments et programme d'avantages complémentaires – Aident les aînés inscrits à assumer le coût des médicaments d'ordonnance, des soins dentaires, des soins de la vue, des services de l'ouïe et des fournitures et pièces d'équipement médicochirurgicales. (*Pharmacare Plan Regulation* et *Extended Health Care Plan Regulation)*

Programme d'assurance-déplacements – Aide les résidents admissibles du Yukon à assumer le coût du transport urgent ou non urgent médicalement nécessaire par voie aérienne ou terrestre. *(Travel for Medical Treatment Act* et *Travel for Medical Treatment Regulation)*

Programme d'assurance-médicaments et de soins de la vue pour les enfants – Aide les familles à faible revenu à assumer le coût des médicaments d'ordonnance, des examens de la vue et des lunettes d'ordonnance pour les personnes de moins de 18 ans. *(Children's Drug and Optical Program Regulation)*

Santé publique – Fait la promotion de la santé et du bien-être partout sur le territoire au moyen de divers programmes de prévention et d'éducation. Ce programme n'est pas imposé par la *Loi*.

Programme de services ambulanciers – Assure la stabilisation de l'état de santé et le transport des personnes malades ou blessées du lieu de l'accident à l'établissement de santé le plus près en mesure de dispenser des soins du niveau requis. Ce programme n'est pas imposé par la *Loi*.

Programme de soins de l'ouïe – Offre aux personnes de tous âges souffrant d'une variété de troubles de l'ouïe des services d'évaluation systématique et de diagnostic. Même des activités de sensibilisation du public. Ce programme n'est pas imposé par la *Loi*.

Programme de soins dentaires – Offre des soins dentaires complets — diagnostic, prévention et restauration — aux enfants du niveau préscolaire à la 8e année, à Whitehorse et à Dawson City. Les soins s'étendent jusqu'à la 12e année (fin du secondaire) dans toutes les autres collectivités du Yukon. Ce programme n'est pas imposé par la *Loi*.

Programme de santé mentale – Offre des services d'évaluation, de diagnostic, de traitement individuel et en groupe, de consultation et de d'aiguillage aux personnes aux prises avec une variété de problèmes de santé mentale. Ce programme n'est pas imposé par la *Loi*.

Documents supplémentaires présentés à Santé Canada

- Listes des services hospitaliers, médicaux et de chirurgie dentaire non assurés
- *Loi sur l'assurance-santé* et son règlement
- *Loi sur l'assurance-hospitalisation* et son règlement
- État des revenus et des dépenses : programmes d'assurance-santé
- Comptes publics du Yukon – extrait du rapport du vérificateur général, 1998-1999
- Comptes publics du Yukon – extrait des états financiers consolidés, 1998-1999
- Budget du Yukon, 2000-2001

Territoires du Nord-Ouest

Aperçu

De concert avec onze conseils de la santé et des services sociaux, le ministère de la Santé et des Services sociaux des Territoires du Nord-Ouest offre un vaste éventail de programmes et de services dans le domaine de l'aide à la famille, de la protection de l'enfance, de la santé publique, des soins à domicile, de la vie autonome, du mieux-être communautaire, de la santé environnementale, des services assurés, des statistiques démographiques et des services de santé complémentaires. Bien que les services assurés comprennent les soins médicaux et les soins hospitaliers, il existe un certain nombre d'autres services supplémentaires tels que l'assurance-médicaments, l'allocation de voyage pour fins médicales et régime d'assurance-maladie complémentaire pour les aînés. Le ministère de la Santé et des Services sociaux des Territoires du Nord-Ouest utilise une approche de la prestation des services qui est fondée sur la collectivité. Les conseils de la santé et des services sociaux dispensent un éventail complet de services de santé communautaires et en établissement. Dans les Territoires du Nord-Ouest, le personnel infirmier est le groupe de professionnels de la santé le plus important. Dans la plupart des collectivités, les infirmières et infirmiers en santé communautaire sont le point d'accès des soins de santé dans les centres de santé communautaire. Les centres de santé offrent des services de traitement ambulatoire réguliers et d'urgence ainsi qu'un programme de santé publique complet. Ils consultent les médecins au besoin. Les travailleurs sociaux fournissent des services sociaux de base, y compris des services de counseling, d'intervention en cas de crise et des programmes de bien-être des enfants.

Dans les collectivités les plus importantes, telles que Yellowknife et Inuvik, les médecins sont souvent le premier point de contact du public avec le système de santé. Un médecin de famille et parfois un spécialiste se rendent périodiquement dans les autres collectivités. Les spécialistes travaillent à l'Hôpital régional Stanton de Yellowknife ou dans des hôpitaux situés dans le sud du Canada. Parmi les spécialités pour lesquelles on trouve des résidents à Stanton, mentionnons l'obstétrique et la gynécologie, la médecine interne, la pédiatrie, l'orthopédie, l'ophtalmologie, les soins des yeux, du nez et de la gorge, la radiologie, la chirurgie générale et la psychiatrie. Des cliniques de consultation spéciale, en neurologie et en cardiologie par exemple, offrent d'autres services de consultation pour les patients provenant des banlieues périphériques.

Évolution sur le plan démographique

Le 1er juillet 2000, les Territoires du Nord-Ouest comptaient environ 42 083 habitants, dont 21 320 sont des Autochtones. La population des T.N.-O. est relativement jeune et le taux de natalité est élevé. Selon le recensement 2000, environ 27 pour cent de la population des Territoires du Nord-Ouest serait âgée de moins de 15 ans, comparativement à 19 pour cent pour la population canadienne dans son ensemble. Étant donné le profil de cette population, il est nécessaire d'investir dans des services ciblant les enfants, les jeunes et les jeunes familles.

Bien que la population des territoires soit relativement jeune, elle est néanmoins vieillissante. D'ici à 2020, le nombre d'aînés de 65 ans et plus passera d'environ 1 700 à plus de 4 400, ce qui représente une augmentation de 160 pour cent. Par contraste, on s'attend à ce que la population âgée de moins de 20 ans augmente de 15 pour cent seulement au cours de la même période. En moyenne, les aînés ont besoin d'un plus grand nombre de services de santé que tout autre groupe d'âge, y compris les nouveau-nés. Parmi les aînés, la demande en ressources en santé est cinq fois plus élevée que parmi la population âgée de moins de 65 ans. Ces chiffres sont liés à une plus forte

incidence de cancers, de problèmes circulatoires, du système nerveux, des maladies d'organes sensoriels, des blessures et des maladies respiratoires comparativement à la population dans son ensemble.

L'évolution des conditions économiques

L'évolution des conditions économiques dans le nord a des répercussions sur la santé et le bien-être des résidents. Les revenus venant de la hausse du taux d'emploi, particulièrement dans les régions où l'on procède à l'exploitation minière, pétrolifère et gazière, ont eu un effet positif sur l'économie. Une augmentation du revenu disponible peut donner lieu à une amélioration de la nutrition, de la sûreté et de la sécurité des familles. Par contre, l'évolution des conditions économiques peut aussi être la source de problèmes sociaux tels que l'alcoolisme ou la passion du jeu. Un emploi précaire est source de stress et peut influer sur le bien-être physique, mental et social. Des études ont démontré que les chômeurs ont une espérance de vie réduite et ont plus de problèmes de santé que les travailleurs. Dans les collectivités de plus petite taille, la faiblesse des revenus des ménages et la réduction de possibilités d'emploi conjuguées à des conditions de logement médiocres entraînent du stress et se traduisent par des conditions de vie malsaines.

Incidence des maladies, des blessures et des décès évitables

Comparativement au reste du Canada, l'incidence des maladies, des blessures et des décès évitables est élevée dans les Territoires du Nord-Ouest (*Rapport d'étape sur la santé 1999*). Des facteurs regrettables tels que la violence familiale, les effets de l'alcool sur le fœtus (EAF) et la plupart des formes de cancer sont liés aux choix médiocres que font les personnes dans leur mode de vie : régime alimentaire, consommation d'alcool, de tabac et de drogues. Les blessures et les décès sont la conséquence de comportements à risques. Bon nombre de besoins de soins aigus et de longue durée sont liés à la pauvreté, à un faible taux d'instruction, au chômage et à une faible estime de soi, tous des facteurs qui peuvent donner lieu à de médiocres capacités d'adaptation.

L'usage du tabac est devenu une grave préoccupation dans le domaine de la santé publique. Dans les Territoires du Nord-Ouest, les taux d'usage du tabac sont parmi les plus élevés au Canada. Les répercussions de l'usage du tabac sur les coûts des soins de santé et les coûts humains en termes de décès et d'incapacités sont très importants et ont tendance à augmenter.

Hausses des coûts des soins de santé et des services sociaux

Des facteurs tels que la démographie, les nouvelles technologies et les pratiques médicales, l'incidence accrue de maladies chroniques et nouvelles, l'utilisation de produits pharmaceutiques qui viennent tout juste d'être mis au point et qui sont plus coûteux ainsi que l'évolution des attentes des citoyens sont tous des facteurs qui ont contribué à augmenter la demande en ressources.

Dans les Territoires du Nord-Ouest, la croissance démographique et l'inflation ont également été des facteurs qui ont entraîné une hausse des coûts liés à la prestation des services de santé et des services sociaux. En d'autres mots, la prestation du même ensemble de services de base coûte cette année davantage qu'elle n'en coûtait l'année dernière. L'augmentation des coûts continue d'exercer de fortes pressions sur le système. Le gouvernement des Territoires du Nord-Ouest peut s'attendre à faire face à des défis semblables.

Maintien d'un système durable

Depuis un certain nombre d'années, la prestation de programmes de santé et de programmes sociaux a constamment fait l'objet de discussions dans les Territoires du Nord-Ouest. Pour pouvoir relever un certain nombre de défis importants, il faudra apporter certains changements. À cet égard, mentionnons assurer la durabilité du système malgré la limitation des ressources et l'augmentation des demandes, des problèmes

touchant la capacité de l'actuel système d'assurer la qualité des soins, la confusion concernant les relations de responsabilisation au sein du système et les défis que pose la coordination de la prestation de services. La difficulté de recruter des professionnels de première ligne, la concurrence croissante des autres provinces et territoires du Canada et d'autres pays ajoutent d'autres pressions sur le système. L'une des priorités de l'administration territoriale est de s'assurer que les programmes et services soient abordables et durables.

Technologie de l'information

Comme la population des Territoires du Nord-Ouest est faible et répartie sur un vaste territoire isolé, les T.N.-O se tournent vers les nouvelles technologies de l'information afin de mieux relier les collectivités entre elles. Parallèlement, l'éloignement de ces collectivités fait en sorte qu'il est coûteux et difficile de trouver des solutions technologiques adéquates et pertinentes et d'assurer le maintien de ces solutions.

Dans tous les territoires et provinces, la qualité et l'intégralité des données représentent un défi, mais ce défi est encore plus difficile à relever dans les T.N.-O. Il est de plus en plus important que l'on mette au point de nouveaux systèmes d'information pour le Ministère et les conseils en tenant compte des problèmes liés à la protection des renseignements des clients.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Le régime d'assurance-santé porte le nom de régime de soins de santé; il comprend le régime de soins médicaux et le régime d'assurance-hospitalisation. Le régime de soins médicaux est placé sous la responsabilité du directeur de l'assurance-maladie, lequel est nommé en vertu de la *Loi sur l'assurance-maladie*. Le ministre gère le régime d'assurance-hospitalisation par l'entremise de conseils d'administration nommés aux termes de la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux (L.R.T.N.-O.)*

Le régime de soins de santé des Territoires du Nord-Ouest est assujetti aux dispositions de la *Loi sur l'assurance-maladie* (révisée en 1988) et de la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux* (révisée en 1988). En janvier 2001, certains articles du règlement pris en application de la *Loi sur l'assurance-maladie* se rapportant aux grilles tarifaires ont été modifiés afin de tenir compte du contrat négocié entre l'Association médicale des T.N.-O. et le ministère de la Santé et des Services sociaux.

Le Directeur de l'assurance-maladie doit fournir les services décrits en détail dans la *Loi sur l'assurance-maladie*. Les responsabilités du ministre sont exposées dans la *Loi sur l'assurance-hospitalisation sur l'administration des services de santé et des services sociaux*.

1.2 Liens hiérarchiques

Le ministre de la Santé et des Services sociaux des Territoires du Nord-Ouest doit nommer un Directeur des soins médicaux qui veillera à l'application de la *Loi sur l'assurance-maladie* et du règlement pris en application de cette loi.

Le ministre doit également désigner les membres du conseil d'administration des établissements des Territoires du Nord-Ouest. Des conseils de gestion sont établis en vertu de l'article 10 de la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux* ou en vertu de la *Loi sur les sociétés*. Les conseils sont établis avec le pouvoir de gérer, de contrôler et de voir au fonctionnement des établissements de santé et de services et, sous réserve de la *Loi sur la gestion des finances publiques* (1987), d'exercer tous les pouvoirs nécessaires et accessoires à ces fonctions. Le président du conseil est nommé à titre amovible, tandis que le mandat des autres membres est de trois ans, jusqu'à un maximum de trois mandats consécutifs. Les comptes des conseils d'administration doivent être vérifiés chaque année.

Chaque année, les comptes des conseils d'administration font l'objet d'une vérification annuelle. Le président de chaque conseil d'administration rencontre régulièrement le ministre. Il profite alors de l'occasion pour communiquer des renseignements non financiers.

1.3 Vérification des comptes

Le régime d'assurance-hospitalisation et le régime de soins médicaux sont gérés par le ministère de la Santé et des Services sociaux. Le Vérificateur général du Canada est chargé de vérifier les paiements effectués dans le cadre du régime de soins médicaux. Conformément à la *Loi sur la gestion des finances publiques*, un vérificateur nommé par le ministre doit, chaque année, vérifier les comptes de chaque conseil d'administration.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les services hospitaliers assurés sont dispensés aux termes de la *Loi sur l'assurance-hospitalisation et de l'administration des services de santé et des services sociaux*. Au 31 mars 2001, quatre hôpitaux et 28 centres de santé fournissaient des services hospitaliers assurés aux malades hospitalisés et aux malades externes dans les Territoires du Nord-Ouest.

Une gamme complète de services hospitaliers assurés sont fournis dans les Territoires du Nord-Ouest. Les conseils d'administration sont habilités à fournir des services supérieurs à ceux jugés comme étant médicalement nécessaires, bien que de tels services ne soient pas couverts par les régimes d'assurance.

Les services assurés offerts aux patients hospitalisés comprennent : l'hébergement et les repas en salle commune; les services infirmiers nécessaires; les services de laboratoire, de radiologie et autres services diagnostiques ainsi que les interprétations nécessaires; les médicaments, les produits biologiques et les préparations connexes prescrits par un médecin et administrés à l'hôpital; les fournitures chirurgicales courantes; l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie; l'usage des services de radiothérapie et de physiothérapie, là où ils existent; les services de psychiatrie et de psychologie fournis dans le cadre d'un programme agréé; les services dispensés par des personnes qui sont rémunérées par l'hôpital; les services fournis par un centre approuvé de désintoxication.

Les services de consultation externe comprennent : les analyses en laboratoire, les radiographies et leurs interprétations, quand ils sont requis par un médecin et dispensés par le service de consultation externe d'un hôpital agréé; les services hospitaliers en rapport avec la plupart des interventions médicales et chirurgicales bénignes; les services de physiothérapie, d'ergothérapie et d'orthophonie dans un hôpital agréé; les services de psychiatrie et de psychologie fournis dans le cadre d'un programme offert dans un hôpital agréé. Dans le Règlement sur les services d'assurance-hospitalisation des Territoires du Nord-Ouest, on trouve une liste détaillée des services dispensés aux patients hospitalisés et des services de consultation externe.

Une liste détaillée des services aux patients hospitalisés et des services de consultation externe assurés est comprise dans le Règlement sur les services d'assurance-hospitalisation des Territoires du Nord-Ouest. Il incombe au ministre d'ajouter des services hospitaliers assurés à la réglementation. Ainsi, sur la recommandation du ministre, le Commissaire peut réglementer les services aux patients hospitalisés et des services de consultation externe assurés auxquels les personnes assurées sont admissibles. Il appartient également au ministre de décider s'il y a lieu de recourir à une consultation publique avant d'apporter des changements à la liste des services assurés.

Lorsque les services ne sont pas offerts dans les Territoires du Nord-Ouest, les résidents les reçoivent dans des hôpitaux d'autres provinces ou territoires. Ces services doivent être médicalement nécessaires et ils peuvent comprendre des transferts d'hôpital à hôpital ou des recommandations des médecins. Les

T.N.-O. offrent une aide pour le transfert médical, un programme de service de santé supplémentaire, qui assure que les résidents des T.N.-O. ont accès aux services médicalement nécessaires.

2.2 Services médicaux assurés

La *Loi sur l'assurance-maladie* et le *Règlement sur les soins médicaux* prévoient la prestation de services médicaux assurés dans les Territoires du Nord-Ouest. Les médecins en titre sont les seuls praticiens autorisés à fournir des services médicaux assurés dans les Territoires du Nord-Ouest. Les médecins doivent être titulaires des permis nécessaires pour exercer leur profession dans les Territoires du Nord-Ouest. Bien que les médecins puissent choisir de se retirer du régime de soins médicaux dans les Territoires du Nord-Ouest, aucun d'eux ne l'a fait au cours de l'exercice.

Une vaste gamme de services médicaux nécessaires sont offerts dans les Territoires du Nord-Ouest. Si un service est considéré comme étant assuré, aucune restriction ne s'applique.

Tous les actes médicalement nécessaires effectués par les médecins sont assurés en vertu du régime de soins médicaux, y compris les services diagnostiques et thérapeutiques approuvés; les services chirurgicaux nécessaires; les soins obstétriques complets; les examens de la vue; les consultations chez un spécialiste même quand le patient n'a pas été renvoyé par un omnipraticien.

Après négociation entre l'Association des médecins des Territoires du Nord-Ouest et le directeur de l'assurance-soins médicaux, de nouveaux services médicaux peuvent être ajoutés au barème d'honoraires applicable dans les Territoires du Nord-Ouest. Le directeur de l'assurance-médicale gère l'ajout d'un service et détermine également s'il est opportun de recourir à des consultations publiques avant que des changements soient apportés aux barèmes approuvés.

2.3 Services de chirurgie dentaire assurés

Les services ne sont assurés que lorsqu'il s'agit d'interventions de chirurgie buccale et maxillo-faciale ou d'interventions dues à une blessure à la mâchoire ou à une maladie de la bouche ou de la mâchoire. Seuls les chirurgiens stomatologistes peuvent présenter des demandes de paiement.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Certains services fournis par les hôpitaux, les médecins et les dentistes ne sont pas couverts par le régime d'assurance-santé des Territoires du Nord-Ouest. Ce sont les services médico-légaux; les examens effectués à la demande d'un tiers; les services non nécessaires du point de vue médical; les immunisations de groupe; la fécondation *in vitro*; les services dispensés par un médecin aux membres de sa famille; les consultations téléphoniques ou les ordonnances fournies par téléphone; la chirurgie esthétique, sauf si elle est médicalement nécessaire; les services dentaires autres que les services de chirurgie buccale et maxillo-faciale nommément désignés; les pansements, les médicaments, les vaccins, les produits biologiques et les préparations connexes; les lunettes et les appareils spéciaux; les plâtres, les appareils chirurgicaux ou les bandages spéciaux; les traitements fournis au cours des services de chiropratique, de podologie, de naturopathie, d'ostéopathie ou de toute autre intervention pratiquée habituellement par des personnes qui ne sont pas médecins, tels que défini dans la *Loi sur l'assurance-maladie* et le *Règlement*; les services de physiothérapie et de psychologie qui n'ont pas été dispensés dans un établissement de consultation externe assuré; les services assurés en vertu de la *Workers' Compensation Act* ou de toute autre loi fédérale ou territoriale; les examens généraux annuels courants, dans les cas où il n'y a pas de diagnostic définissable.

3.0 Universalité

3.1 Admissibilité au régime

La *Loi sur l'assurance-maladie* est la loi qui définit l'admissibilité des résidents des Territoires du Nord-Ouest au régime d'assurance-santé du territoire.

Pour définir l'admissibilité, on a recours à l'entente interprovinciale sur l'admissibilité et la transférabilité et aux directives d'inscription au régime de soins médicaux des Territoires du Nord-Ouest. Aucune modification en matière d'admissibilité n'a été apportée au cours de l'exercice 2000-2001.

Le régime de soins médicaux des Territoires du Nord-Ouest exclut les membres des Forces armées canadiennes, les membres de la Gendarmerie royale du Canada, les personnes purgeant une peine d'emprisonnement dans un pénitencier du gouvernement fédéral et les résidents dont la période d'attente minimale n'est pas terminée.

3.2 Exigences relatives à l'inscription au régime

Pour s'inscrire au régime, les personnes doivent remplir un formulaire de demande et fournir les documents justificatifs pertinents (visas, documents d'immigration, etc.). Les personnes doivent être en mesure de fournir, sur demande, une preuve de résidence. Au mieux, l'inscription devrait avoir lieu avant la date d'admissibilité réelle du résident. Les cartes de soins de santé sont renouvelés tous les deux ans. L'inscription est directement liée à l'admissibilité au régime. Les demandes de remboursement présentées par les résidents dont l'inscription n'est pas valide ne sont pas acceptées.

Au 31 mars 2001, 41 673 résidents étaient inscrits au régime de soins de santé des Territoires du Nord-Ouest.

Le régime de soins de santé ne prévoit aucune possibilité de retrait officielle pour les patients.

3.3 Autres catégories de personnes assurées

Les titulaires d'un visa d'emploi, d'un visa d'étudiant et, dans certains cas, d'un visa de visiteur sont couverts par le régime si leur visa est valide pour une période d'au moins 12 mois.

4.0 Transférabilité

4.1 Délai minimal de résidence

L'entente interprovinciale sur l'admissibilité et la transférabilité fixe un délai de résidence aux personnes assurées qui déménagent d'une province ou d'un territoire pour s'installer dans les Territoires du Nord-Ouest. En général, un résident n'est pas assuré avant le premier jour du troisième mois et, dans certains cas, avant le premier jour du treizième mois.

4.2 Couverture durant des absences temporaires (au Canada)

L'entente interprovinciale sur l'admissibilité et la transférabilité et les directives d'inscription au régime de soins de santé des Territoires du Nord-Ouest définissent les règles de transférabilité de l'assurance-santé pendant des absences temporaires au Canada.

Les étudiants qui s'absentent temporairement des Territoires du Nord-Ouest sont couverts par l'assurance-santé pendant la période où ils fréquentent à temps plein un établissement d'enseignement postsecondaire. Les personnes qui, pour diverses raisons (travail, vacances, détachements, etc.), prévoient s'absenter des Territoires du Nord-Ouest pour une période d'un an ou moins demeurent assurées pendant un maximum d'une année. Lorsqu'une personne est autorisée à s'absenter temporairement des Territoires du Nord-Ouest, le coût d'une année des services assurés reçus dans d'autres provinces ou territoires est entièrement payé.

Les Territoires du Nord-Ouest ont signé des ententes de facturation réciproque des services hospitaliers et médicaux assurés avec les autres provinces et territoires.

4.3 Couverture durant des absences temporaires (à l'étranger)

Les directives touchant l'inscription au régime de soins de santé des Territoires du Nord-Ouest exposent les critères qui définissent la protection assurée pendant les séjours à l'étranger. Le régime couvre les personnes qui s'absentent du pays pour une raison ou pour une autre pendant une période pouvant aller jusqu'à un an.

L'alinéa 11. (b) (ii) de la *Loi canadienne sur la santé* stipule que les résidents peuvent présenter les reçus des coûts engagés pour des services fournis à l'étranger. Le remboursement est établi d'après le montant qu'aurait versé les Territoires du Nord-Ouest pour les mêmes services.

4.4 Nécessité d'obtenir une approbation préalable

Pour ce qui est de l'exigence voulant que l'on obtienne l'approbation voulue avant de recevoir certains services dans d'autres provinces ou territoires et à l'extérieur du pays, les Territoires du Nord-Ouest exigent que l'on obtienne une approbation préalable si l'on envisage de se prévaloir de la protection prévue pour ces services. Il est également nécessaire d'obtenir au préalable une approbation si les services assurés doivent être obtenus auprès d'établissements privés.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

Dans les Territoires du Nord-Ouest, tous les résidents ont droit à un programme d'aide financière pour les déplacements à des fins médicales ainsi qu'à un programme de prestations complémentaires de santé destiné à lever tous les obstacles d'ordre économique. L'article 14 de la *Loi sur l'assurance-maladie* stipule que la surfacturation n'est pas autorisée.

5.2 Accès aux services hospitaliers assurés

Dans les Territoires du Nord-Ouest, l'accès aux lits ne pose pas de problème. S'il en était autrement, les résidents seraient transportés dans un autre établissement où l'on trouve les lits appropriés. Au 31 mars 2001, les hôpitaux et les centres de santé des Territoires du Nord-Ouest ont éprouvé certains problèmes de dotation en personnel à court terme, lesquels se sont répercutés négativement sur les activités. Grâce à certains arrangements touchant les déplacements à des fins médicales, l'accès aux services a toutefois été maintenu.

On reconnaît que les établissements des Territoires du Nord-Ouest ne sont pas en mesure d'offrir une vaste gamme de services médicaux, de chirurgie, de réadaptation et de diagnostic. On a mis en oeuvre le Programme d'aide financière pour les déplacements à des fins médicales afin de permettre aux résidents de recevoir les services nécessaires dans les établissements qui les offrent.

Au cours de l'exercice 2000-2001, l'élargissement du projet de télésanté est l'une des mesures qui ont été prises pour améliorer l'accès aux services hospitaliers assurés. L'élargissement originalement prévu pour l'exercice 2000-2001 n'a pas été terminé étant donné que l'équipement nécessaire n'était pas disponible. Toutefois, un certain nombre de mesures ont été prises pendant la période de référence pour assurer que l'installation de l'équipement et la mise à niveau des trois sites WestNet existants (Inuvik, Fort Smith et Yellowknife) sont terminées en 2001-2002. Dans les Territoires du Nord-Ouest, les listes d'attente pour les services hospitaliers assurés ne sont pas longues. La réduction du délai d'attente ne fait donc pas partie des projets ciblés.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Les habitants des Territoires du Nord-Ouest ont accès à tous les établissements gérés par le gouvernement des Territoires du Nord-Ouest.

Le Programme d'aide financière pour les déplacements à des fins médicales permet aux résidents d'accéder aux services médicaux; le projet de télésanté a permis de faciliter l'accès aux services spécialisés des résidents de régions isolées.

5.4 Rémunération des médecins

Dans les Territoires du Nord-Ouest, la *Loi sur l'assurance-maladie* et le *Règlement sur les soins médicaux* régissent les paiements versés aux médecins. Les T.N.-O. recourent à deux modes de rémunération des médecins : le régime de la rémunération des services et les accords contractuels. En l'an 2000, la majorité des médecins de famille qui étaient rémunérés selon le régime de la rémunération des services se sont retirés de ce régime et ont conclu un accord contractuel avec les Territoires du Nord-Ouest.

La rémunération à l'acte des médecins est établie à la suite de négociations entre la *Northwest Territories Medical Association* et le ministère de la Santé et des Services sociaux. Le directeur de l'assurance-soins médicaux et ses représentants négocient au nom du Ministère, et la *Northwest Territories Medical Association* choisit, parmi ses membres, les personnes qui feront partie de l'équipe de négociation.

Le gouvernement des Territoires du Nord-Ouest et la *Northwest Territories Medical Association* ont conclu une entente sous forme de règlement d'application de la *Loi sur l'assurance-maladie*, qui a maintenant force de loi. Ce règlement vise la période débutant en avril 1997 et se terminant le 31 mars 2000. L'entente actuelle est en vigueur jusqu'au 31 mars 2002.

5.5 Paiements aux hôpitaux

Les paiements aux hôpitaux sont effectués conformément aux accords de contribution conclus entre les conseils d'administration et le ministère de la Santé et des Services sociaux. Les sommes allouées aux termes des accords sont établies d'après les ressources disponibles dans le budget global du gouvernement et le niveau de service assuré par l'hôpital.

Les paiements versés aux établissements dispensant des services hospitaliers assurés sont régis par la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux* ainsi que la *Loi sur la gestion des finances publiques*. Aucune modification n'a été apportée au processus au cours de l'exercice 2000-2001. Les hôpitaux des Territoires du Nord-Ouest sont financés au moyen d'un budget global.

6.0 Reconnaissance accordée aux transferts fédéraux

Le gouvernement des Territoires du Nord-Ouest a rendu compte des fonds versés par le gouvernement fédéral dans le cadre du Transfert canadien en matière de santé et de programmes sociaux du Canada dans des communiqués de presse et dans divers autres documents. Pour l'exercice 2000-2001, on y trouvait les documents suivants :

- le Discours budgétaire 2000;
- le Budget principal des dépenses 2000-2001;
- les Comptes publics 1999-2000.

Les Plans d'activités pour le ministère des Finances et le ministère de la Santé et des Services sociaux.

Le Budget principal des dépenses susmentionné représente le plan financier du GTNO et le gouvernement le présente chaque année à l'Assemblée législative.

7.0 Services complémentaires de santé

Les soins offerts dans les maisons de repos sont assurés dans le cadre du régime d'assurance-hospitalisation et fournis pour certains lits désignés d'établissements d'Inuvik, de Yellowknife, de Hay River et de Fort Smith.

Les conseils de la santé et des services sociaux reçoivent leurs fonds de base du ministère de la Santé et des Services sociaux afin qu'ils offrent

des services de soins à long terme aux résidents des Territoires du Nord-Ouest. Ces services comprennent des établissements de soins de longue durée, des foyers de groupe, des options d'aide à la vie autonome de même que des soins à domicile.

Les établissements de soins de longue durée offrent des soins médicaux et personnels complexes. Les foyers de groupe offrent des services à la population de tout âge en se fondant, pour ce faire, sur une évaluation de leurs besoins afin de leur permettre de continuer à mener, aussi longtemps que possible, une vie autonome au sein de la collectivité et dans leur propre maison dans le but d'éviter ou de reporter le placement en établissement.

Lorsque les services requis ne sont pas offerts dans les Territoires du Nord-Ouest, les clients sont logés dans des établissements de soins situés dans le sud du Canada.

Renseignements supplémentaires

Dans les Territoires du Nord-Ouest, le système de santé des services sociaux a été revu en profondeur au cours des quelques dernières années – le Comité spécial de l'Assemblée législative sur la santé et les services sociaux (1993), l'examen Med-Emerg (1998). Pendant la période de référence, on a reçu le rapport du forum du ministre sur la santé et les services sociaux. À l'occasion du Forum du ministre, on a exhorté le gouvernement à adopter des mesures touchant la structure de la commission et son financement. Aucune suggestion précise n'a toutefois été formulée. On trouve un exemplaire du rapport ainsi que d'autres documents produits par le ministère de la Santé et des Services sociaux des Territoires du Nord-Ouest sur le site suivant :

www.hlthss.gov.nt.ca

De plus, on trouve les lois, les règlements et d'autres documents tels que le Budget principal des dépenses à l'adresse [www.gov.nt.ca]. Pendant la période de référence, on n'a procédé à aucune vérification du régime d'assurance-santé.

Nunavut

Aperçu

Le territoire du Nunavut a été établi le 1er avril 1999. Sa superficie représente le cinquième de la masse continentale du Canada. On y recense 26 collectivités couvrant trois fuseaux horaires. Selon les statistiques récentes, la population du Nunavut est de 27 692 personnes, dont la majorité – 85 % – sont des Inuits. Une petite communauté de francophones (4 à 6 % de la population) vit sur l'île de Baffin, principalement dans la capitale Iqaluit. De plus, le Nunavut compte beaucoup de travailleurs migrants, dont des ouvriers qualifiés et d'autres saisonniers provenant d'autres provinces et territoires.

Les lois régissant l'administration de la santé et des services sociaux au Nunavut sont issues des Territoires du Nord-Ouest et constituent les lois du Nunavut, en vertu de la *Loi sur le Nunavut* de 1999. Au cours des années à venir, le ministère de la Santé et des Services sociaux a l'intention d'examiner toutes les lois en vigueur afin de s'assurer de leur pertinence et de leur bien-fondé pour le gouvernement du Nunavut, comme l'exigent les objectifs du mandat Bathurst. Ce mandat expose le programme préconisé par le gouvernement en vue d'édifier des collectivités saines, de favoriser la simplicité et l'unité, l'autonomie et l'éducation permanente. On s'attend à ce que tous les ministères intègrent les valeurs inuits traditionnelles, qu'on appelle Qaujimanituqangit, dans l'élaboration des politiques, la conception et la prestation des services.

La prestation des services de santé au Nunavut repose sur un modèle de soins primaires. Il y a un centre de santé communautaire dans chacune des 25 collectivités et il y a un hôpital régional à Iqaluit. Les principaux dispensateurs de soins de santé sont les infirmières praticiennes. Douze médecins travaillent à l'hôpital, et trois autres exercent dans le privé (deux à Iqaluit et un à Pond Inlet). Nunavut fait souvent appel à la Northern Medical Unit de l'Université du Manitoba, au Ottawa Health Services Network Inc. et au Stanton Regional Hospital à Yellowknife pour la majorité des services de médecins et de spécialistes.

La gestion et la prestation des services de santé au Nunavut sont maintenant intégrées dans les activités globales du ministère de la Santé et des Services sociaux. Les anciens conseils régionaux de santé (Baffin, Kitikmeot et Keewatin) ont été dissous le 31 mars 2000. Le membres du personnel des anciens conseils sont maintenant des employés du ministère. On a continué de privilégier l'aide à la prestation des services de première ligne tout au long de ce regroupement.

En 2000-2001, le budget territorial pour la santé et les services sociaux s'élevait à 115,9 millions de dollars, auquel se superpose un supplément de 4,3 millions de dollars au titre des immobilisations. Seul le ministère de l'Éducation dispose d'un budget plus important.

En 2000-2001, des services de télésanté ont été mis en oeuvre dans cinq collectivités. En mars 2001, le ministère a été informé que sa proposition dans le cadre du Programme de partenariats pour l'infostructure canadienne de la santé (PPICS) a été approuvée; elle permettra l'élargissement des services de télésanté à dix autres collectivités au cours des deux prochaines années.

Le Nunavut a de nombreux besoins et des problèmes uniques en ce qui a trait à la santé et au bien-être de ses résidents. Environ le cinquième du budget du ministère est consacré aux voyages pour soins médicaux. En raison de la très faible densité de population dans ce vaste territoire et de l'infrastructure de santé limitée (équipements et ressources humaines), l'accès à un éventail de services hospitaliers et de spécialistes oblige les résidents à se rendre à l'extérieur du territoire. On prévoit de construire un nouvel hôpital régional à Iqaluit et un nouvel établissement de santé régional à Rankin Inlet et Cambridge Bay au cours des trois prochaines années. Cela permettra au Nunavut de renforcer ses capacités internes et d'étoffer la gamme de services offerts.

L'incidence des maladies respiratoires comme la tuberculose demeure élevée. Malgré les activités énergiques de recrutement et de maintien en poste à l'échelle nationale et internationale, le Nunavut est aux prises avec une grave pénurie d'infirmières.

Les activités de promotion et de prévention en matière de santé figurent en tête de liste des priorités du ministère. Il s'agit entre autres des stratégies de réduction du tabagisme et de l'éducation publique sur les choix de vie sains et l'importance des aliments traditionnels.

1.0 Gestion publique

1.1 Régime d'assurance-santé et autorité publique

Les régimes d'assurance-santé, qui couvrent notamment les services médicaux et hospitaliers, sont gérés par le ministère de la Santé et des Services sociaux.

La *Medical Care Act* (T.-N.-O., 1988 et reproduite pour le Nunavut par l'article 29 de la *Loi sur le Nunavut, 1999*) régit l'admissibilité aux services médicaux assurés et leur paiement. La *Hospital Insurance and Health and Social Services Administration Act* (T.-N.-O., 1988 et reproduite pour le Nunavut par l'article 29 de la *Loi sur le Nunavut*, 1999) permet l'établissement de services hospitaliers et d'autres services de santé.

Par la *Dissolution Act* (Nunavut, 1999), les trois anciens Conseils de santé et de services sociaux de Baffin, Kitikmeot et Keewatin ont été dissous. Leurs activités ont été intégrées dans celles du ministère de la Santé et des Services sociaux le 1er avril 2000. Les centres régionaux ont été conservés afin d'appuyer les travailleurs de première ligne et la prestation d'un large éventail de services de santé et de services sociaux.

1.2 Liens hiérarchiques

Le directeur des soins médicaux, nommé en vertu de la *Medical Care Act*, voit à la gestion du régime de soins médicaux du territoire. Il relève du ministère de la Santé et des Services sociaux et doit déposer chaque année un rapport annuel sur les activités du régime de soins médicaux. Le ministère prévoit de déposer ses premiers rapports pour 1999-2000 et 2000-2001 devant l'assemblée législative en février 2002. Nos présentations annuelles aux fins du *Rapport annuel sur la Loi canadienne de la santé* servent de fondement à ces rapports en vertu de la *Medical Care Act*.

1.3 Vérification des comptes

Le vérificateur général du Canada agit à titre de vérificateur du gouvernement du Nunavut, conformément à l'article 30.1 de la *Financial Administration Act (*Nunavut, 1999) Son mandat est de vérifier les activités du ministère de la Santé et des Services sociaux.

Le vérificateur général du Canada doit vérifier chaque année les transactions et les états financiers consolidés du gouvernement. La vérification la plus récente, visant l'exercice finissant au 31 mars 2001, était en cours en septembre 2001.

2.0 Intégralité

2.1 Services hospitaliers assurés

Les services hospitaliers sont dispensés en vertu des articles 2 à 4 de la *Hospital and Social Services Administration Act and Regulations*.. Aucune modification n'a été apportée à la loi ou aux règlements en 2000-2001.

En 2000-2001, des services hospitaliers assurés ont été fournis dans 26 établissements situés sur l'ensemble du territoire, à savoir un hôpital général à Iqaluit et 25 centres de santé communautaire. Le Baffin Regional Hospital d'Iqaluit est le seul établissement de soins actifs au Nunavut offrant une gamme de services hospitaliers aux malades hospitalisés et externes, tels que définis dans la *Loi*

canadienne sur la santé. Les centres de santé communautaire offrent des services de santé publique et de salles d'urgence et certains services de nuit (observations). De plus, il existe un nombre limité de lits d'accouchement au Rankin Inlet Birth Centre.

Le ministère est responsable d'autoriser d'exercer, inspecter et de superviser tous les établissements de santé et de services sociaux du Nunavut.

Les services assurés fournis aux malades hospitalisés comprennent :

- l'hébergement et les repas en salle commune;
- les services infirmiers nécessaires;
- les services de laboratoire, de radiologie et autres services diagnostiques, ainsi que les interprétations nécessaires; les médicaments, les préparations biologiques et connexes prescrits par un médecin et administrés à l'hôpital;
- les fournitures chirurgicales courantes;
- l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie;
- l'usage des services de radiothérapie et de physiothérapie, là où ils existent; les services de psychiatrie et de psychologie fournis dans le cadre d'un programme agréé;
- les services dispensés par des personnes rémunérées par l'hôpital;
- les services fournis par un centre approuvé de désintoxication.

Les services de consultation externe comprennent :

- les examens de laboratoire et les radiographies, y compris les interprétations, quand ils sont requis par un médecin et dispensés par un établissement de consultation externe ou un hôpital agréé;
- les services hospitaliers en rapport avec la plupart des interventions médicales et chirurgicales bénignes;
- les services de physiothérapie, d'ergothérapie, d'audiologie et d'orthophonie fournis dans les établissements par un établissement de consultation externe ou un hôpital agréé;
- les services de psychiatrie et de psychologie fournis dans le cadre d'un programme offert par un hôpital agréé.

Le ministère de la Santé et des Services sociaux ajoute des services assurés dans ses établissements d'après la disponibilité de l'équipement et des ressources adéquates et la faisabilité globale, conformément aux lignes directrices financières établies par le ministère et avec l'aval du conseil de gestion financière du Nunavut. Aucun nouveau service n'a été ajouté en 2000-2001 à la liste des services hospitaliers assurés.

2.2 Services médicaux assurés

Le paragraphe (1) de l'article 3 de la *Medical Care Act* et l'article 3 des *Medical Care Regulations* prévoient la prestation de services de médecin assurés au Nunavut. Aucune modification n'a été apportée à la loi ou aux règlements en 2000-2001.

Les médecins en titre sont les seuls professionnels autorisés à fournir des services de médecin assurés au Nunavut. Le médecin doit être membre en règle d'un collège des médecins et chirurgiens et doit être autorisé à exercer au Nunavut. Le comité d'inscription des médecins du gouvernement des Territoires du Nord-Ouest gère ce processus pour les médecins du Nunavut. Quinze médecins (trois qui exercent dans le privé et douze au Baffin Regional Hospital) dispensent actuellement des services aux malades du Nunavut. Les spécialistes en visite, les omnipraticiens et les médecins suppléants peuvent également dispenser des services de médecin assurés, par l'entremise d'accords conclus par chacune des trois régions du ministère.

Les médecins peuvent recevoir des honoraires autres que ceux qui sont énumérés dans le régime de soins médicaux, conformément à

l'alinéa (a) ou (b) du paragraphe 2 de l'article 12 de la *Medical Care Act*, en avisant le directeur par écrit de cette décision. Ce choix peut être révoqué le premier jour du mois suivant, moyennant l'envoi d'une lettre à cet effet au directeur. En 2000-2001, aucun médecin n'a fait ce choix.

Les services de médecin assurés regroupent tous les services médicalement nécessaires rendus par des médecins. Lorsque les services assurés ne peuvent être fournis au Nunavut, le malade est renvoyé dans une autre province ou un autre territoire.

L'ajout ou le retrait d'un service de médecin à la liste des services assurés nécessite l'approbation du territoire. En 2000-2001, aucun ajout ou retrait n'a été fait.

2.3 Services de chirurgie dentaire assurés

Les dentistes fournissant des services de chirurgie dentaire assurés en vertu du régime de soins médicaux doivent détenir un permis d'exercer, conformément à la *Dental Professions Act* (T.-N.-O, 1988 et reproduite pour le Nunavut par l'article 29 de la *Loi sur le Nunavut*, 1999). Ils reçoivent des numéros à apposer aux factures présentées aux responsables du régime concernant la prestation de services dentaires assurés. En 2000-2001, trois chirurgiens stomatologistes ont reçu l'autorisation de facturer des services dentaires assurés au régime de soins médicaux du Nunavut.

Les services dentaires assurés se limitent aux actes de chirurgie dentaire qui figurent dans les règlements et qui nécessitent des ressources accessibles uniquement dans des hôpitaux pour être accomplis (p. ex., chirurgie pour corriger un prognathisme).

L'ajout de nouveaux services de chirurgie dentaire à la liste des services assurés doit être approuvé par le territoire. Aucun nouveau service n'a été ajouté à la liste en 2000-2001.

2.4 Services hospitaliers, médicaux et de chirurgie dentaire non assurés

Les services fournis en vertu de la *Workers' Compensation Act* (T.-N.-O., 1988 et reproduite pour le Nunavut par l'article 29 de la *Loi sur le Nunavut*, 1999) ou d'autres lois du Canada, sauf la *Loi canadienne sur la santé*, sont exclus.

Les services non assurés fournis par des médecins comprennent les suivants :

- examens physiques annuels;
- chirurgies esthétiques;
- services considérés expérimentaux;
- médicaments d'ordonnance;
- examens physiques exécutés à la demande d'un tiers;
- services d'optométrie;
- services dentaires autres que certains actes liés à des maladies ou à des blessures de la mâchoire;
- services de chiropraticiens, de naturopathes, de podiatres et d'ostéopathes, et traitements d'acupuncture; et
- services de physiothérapie, d'orthophonie et de psychologie reçus dans un établissement qui n'offre pas de services de consultation externe assurés (hôpital).

Les services non assurés fournis en milieu hospitalier comprennent les suivants :

- frais hospitaliers excédant le taux de l'hébergement en salle commune pour une chambre privée ou semi-privée;
- services qui ne sont pas médicalement nécessaires, comme la chirurgie esthétique;
- services considérés comme expérimentaux;
- frais d'ambulance (sauf pour les transferts entre les hôpitaux);
- services dentaires autres que certains actes liés à des maladies ou à des blessures de la mâchoire; et
- services de réadaptation pour les alcooliques et les toxicomanes, sauf ceux pour lesquels une autorisation préalable a été consentie.

Le Baffin Regional Hospital facture 2 180,25 dollars par jour pour les services fournis aux étrangers qui y séjournent.

Lorsque des résidents sont envoyés à l'extérieur du territoire pour y recevoir des services, le ministère s'inspire des politiques et des procédures de la province ou du territoire concerné lorsqu'il est question de fournir des services à des résidents du Nunavut qui peuvent entraîner des frais supplémentaires, mais seulement dans la mesure où ces coûts sont visés par le régime de soins médicaux du Nunavut (voir la section 4.2, Transférabilité). Les demandes ou plaintes sont traitées individuellement par la province ou le territoire concerné.

Le ministère gère également le Programme des services de santé non assurés (SSNA) au nom de Santé Canada pour les résidents des Premières Nations et les Inuits. Le SSNA couvre une quote-part au titre des déplacements pour soins médicaux, de l'hébergement et des repas dans les pensions (à Ottawa, Winnipeg, Churchill, Edmonton et Yellowknife), les médicaments prescrits, les traitements dentaires, les soins de la vue, les fournitures médicales et les prothèses, et un certain nombre d'autres services secondaires.

3.0 Universalité

3.1 Admissibilité au régime

L'admissibilité au régime d'assurance-santé du Nunavut est brièvement définie dans les paragraphes (1), (2) et (3) de l'article 3 de la *Medical Care Act*. Le Ministère respecte également l'*Entente interprovinciale et territoriale en matière d'admissibilité et de transférabilité* et les lignes directrices internes.

Aux termes de ces dispositions, tous les résidents du Nunavut sont admissibles à des services de santé assurés et y ont droit en vertu de modalités uniformes. Le définition du mot « résident » est la suivante : personne légalement autorisée à être ou à rester au Canada, domiciliée et résidant habituellement au Nunavut, à l'exception d'une personne faisant du tourisme, de passage ou en visite.

Les demandes de participation au régime sont acceptées et des documents à l'appui sont exigés pour confirmer le statut de résident. Les résidents admissibles reçoivent une carte de santé comportant un numéro distinct. La protection débute généralement le premier jour du troisième mois suivant l'arrivée, mais une couverture peut être accordée à partir du tout premier jour dans certaines circonstances (p. ex., nouveau-né dont la mère ou le père est admissible à la couverture). Les résidents permanents, dont les immigrants admis, les Canadiens de retour au pays, les résidents permanents de retour au pays et les non-Canadiens à qui l'on a délivré un visa d'emploi pour une période de douze mois ou plus ont également droit à la couverture dès le tout premier jour.

Les membres des Forces canadiennes et de la Gendarmerie royale du Canada et les détenus des pénitenciers fédéraux ne sont pas admissibles à la couverture. En vertu du régime d'assurance-santé du Nunavut, ces groupes ont droit à la protection au premier jour de leur libération.

Conformément à l'article 7 de l'*Entente interprovinciale et territoriale en matière d'admissibilité et de transférabilité*, les personnes qui sont temporairement absentes de leur province ou territoire d'origine et qui n'élisent pas domicile au Nunavut demeurent inscrites aux régimes de soins médicaux de leur province ou territoire d'origine pendant une durée maximale d'un an.

3.2 Exigences relatives à l'inscription au régime

Pour s'inscrire au régime, une personne doit présenter un formulaire de demande rempli et des documents à l'appui. Une carte de santé est délivrée à chaque résident. Le Nunavut entreprendra un renouvellement progressif lorsque que le nouveau système de facturation sera en mis en place, au cours du prochain exercice. Aucune prime n'est exigible. Même si la protection en vertu du régime d'assurance-santé du Nunavut est liée à la vérification de l'inscription, tous les efforts sont consentis pour que les résidents admissibles soient couverts lorsqu'ils ont besoin de la protection. Les non-

résidents doivent posséder une carte de santé valide, délivrée par leur province ou territoire d'origine, pour avoir accès aux services de santé assurés.

Au 31 mars 2001, environ 26 887 résidents étaient inscrit au régime d'assurance-santé du Nunavut. Les statistiques sur la population du Nunavut, publiées par Statistique Canada, font état d'un certain nombre de « résidents temporaires », qui ne sont pas admissibles à la couverture en vertu du régime du territoire. Aucune disposition ne prévoit la possibilité, pour les résidents, de se retirer du régime d'assurance-santé.

3.3 Autres catégories de personnes

Les non-Canadiens détenteurs de visas d'emploi ou de visas d'étudiant valides durant moins de 12 mois, les travailleurs de passage et les détenteurs de permis ministériels (sauf exception) ne sont pas admissibles au régime. Lorsqu'une situation particulière se présente, une évaluation individuelle est effectuée, en conformité avec l'article 15 des lignes directrices du T.-N.-O. sur l'inscription au régime de santé, adoptées par le Nunavut en 1999.

4.0 Transférabilité

4.1 Délai minimal de résidence

Conformément à l'article 3 de l'*Entente interprovinciale et territoriale en matière d'admissibilité et de transférabilité*, le résidence exigée pour la couverture des personnes arrivant d'ailleurs au Canada est de trois mois ou, alors, la protection commence le premier jour du troisième mois suivant l'établissement de la résidence dans le territoire ou le premier jour du troisième mois, lorsqu'une personne qui a été temporairement absente de sa province ou de son territoire d'origine décide d'établir sa résidence permanente au Nunavut.

4.2 Couverture durant les absences temporaires (au Canada)

Le paragraphe (2) de l'article 4 de la *Medical Care Act* stipule que les services médicaux sont assurés lorsqu'ils sont fournis à l'extérieur du territoire, mais au Canada. La *Hospital Insurance and Health and Social Services Administration Act*, alinéas 5 d) et 28(1)j) et o), donne au ministre l'autorité de conclure des accords avec d'autres provinces ou territoires concernant la prestation de services de santé aux résidents du Nunavut et d'établir les modalités de paiement. En 2000-2110, aucun changement n'a été apporté aux lois ou règlements en ce qui a trait à la couverture à l'extérieur du Nunavut.

Les personnes qui étudient à l'extérieur du Nunavut doivent aviser le ministère et fournir une preuve d'inscription pour s'assurer une couverture continue. Les demandes de prolongement doivent être renouvelées chaque année et approuvées par le directeur. Les absences temporaires d'au plus un an pour le travail, des vacances ou d'autres raisons sont approuvées par le directeur, moyennant la présentation d'une demande écrite de l'assuré. Le directeur peut approuver des absences qui excèdent douze mois consécutifs, moyennant la présentation d'une demande écrite de l'assuré.

Les dispositions relatives à la protection durant les absences temporaires au Canada sont parfaitement conformes aux modalités de l'*Entente interprovinciale et territoriale en matière d'admissibilité et de transférabilité* signée le 1er janvier 1998.

Le Nunavut participe à la facturation réciproque des médecins et des hôpitaux; des accords ont été conclus avec d'autres provinces et territoires (Ontario, Manitoba, Alberta et Territoires du Nord-Ouest) à cet effet.

Le paiement des services hospitaliers assurés fournis à l'extérieur du territoire à des malades hospitalisés ou externes admissibles qui habitent au Nunavut est accordé en vertu des accords de facturation réciproque des hôpitaux.

Les coûts élevés de certains actes médicaux, les frais pour les accouchements et les coûts des consultations externes sont déterminés par le comité de coordination sur la facturation réciproque. Un accord spécial a été conclu entre les Territoires du Nord-Ouest et le Nunavut. Reposant sur une approche axée sur le financement global, cet accord permet au Stanton Hospital de Yellowknife de fournir des services aux résidents du Nunavut, à l'hôpital et par l'entremise de visites de spécialistes dans la région de Kitikmeot (Grand Nord).

Le paiement des services de médecin assurés fournis à l'extérieur du territoire aux résidents du Nunavut admissibles est versé en vertu des accords de facturation réciproque. Le paiement est délivré à la province d'accueil aux taux établis par cette dernière.

Durant l'exercice 2000-2001, les réclamations payées pour des services hospitaliers dispensés hors territoire totalisaient 17 221 306,62 dollars, dont 3 381 922,33 dollars pour l'exercice 1999-2000.

4.3 Couverture durant les absences temporaires (à l'étranger)

Le paragraphe (3) de l'article 4 de la *Medical Care Act* stipule que les services médicaux sont assurés lorsqu'ils sont fournis à l'extérieur du Canada. Les alinéas 28(1)j) et o) de la *Hospital Insurance and Health and Social Services Administration Act* donne au ministre l'autorité d'établir les modalités de paiement pour des services fournis aux résidents du Nunavut à l'extérieur du Canada. Les personnes ont droit à une couverture durant une période maximale d'un an lorsqu'elles s'absentent temporairement du pays, peu importe la raison, mais doivent toutefois présenter un avis écrit au préalable. Lorsque les résidents sont renvoyés à l'extérieur du pays pour recevoir des services (actes hautement spécialisés qui ne peuvent être fournis ni au Nunavut ni au Canada), le territoire assume la totalité des frais.

Concernant les services non urgents ou qui n'ont pas fait l'objet d'un renvoi, le paiement des frais hospitaliers s'établit à 1 396,00 $ par jour et à 110,00 dollars par consultation externe. Aucun changement n'a été apporté à ces taux en 2000-2001.

Les services de médecin assurés fournis à des résidents admissibles temporairement absents du pays sont payés à des taux équivalents à ceux payés pour les mêmes services dans le territoire. Le remboursement est effectué soit au nom de l'assuré, soit directement au fournisseur du service assuré.

4.4 Nécessité d'une approbation préalable

Il est nécessaire d'obtenir une approbation préalable pour la prestation de services facultatifs dans des établissements privés canadiens ou dans tout établissement situé à l'extérieur du pays.

5.0 Accessibilité

5.1 Accès aux services de santé assurés

L'article 14 de la *Medical Care Act* interdit la surfacturation, sauf si le médecin a pris une décision à cet effet qui soit encore valide. L'accès aux services assurés repose sur des modalités uniformes. Pour régler les problèmes posés par la distance et les frais de déplacement, le gouvernement du Nunavut fournit une aide au déplacement pour des raisons médicales. Des services d'interprétation sont également offerts aux patients lorsqu'ils sont nécessaires en milieu médical.

5.2 Accès aux services hospitaliers assurés

Le Baffin Regional Hospital d'Iqaluit est le seul établissement de soins actifs au Nunavut. Il dispose de 25 lits, mais en raison d'une pénurie d'infirmières, seulement 16 lits en moyenne étaient disponibles pour les services de soins

actifs, de réadaptation et de soins aux malades chroniques en 2000-2001. Son personnel compte 101 personnes, dont 12 médecins et 33 infirmières. L'établissement fournit des services aux malades hospitalisés et externes de même que des services d'urgence 24 heures sur 24. Les médecins locaux dispensent des services d'urgence en rotation. Les services médicaux comprennent les soins ambulatoires, les consultations externes, les services de soins intensifs, le traitement des problèmes respiratoires et cardiovasculaires, les services d'obstétrique de même que le traitement des saignements gastro-intestinaux et de l'hypertension. Certains services chirurgicaux sont offerts : soins orthopédiques mineurs, gynécologie, pédiatrie, troubles gastriques généraux, trauma (urgence) et ORL/oto-rhino-laryngologie. Les pateints qui ont besoin de chirurgies spécialisées sont renvoyés dans des centres à l'extérieur du territoire. Les services de diagnostic comprennent les services de radiologie, de laboratoire et d'électrocardiogramme. Les services de réadaptation sont limités à Iqaluit.

Le Nunavut a conclu des accords spéciaux avec des établissement d'Ottawa, de Toronto, de Churchill, de Winnipeg, d'Edmonton et de Yellowknife concernant la prestation de services assurés aux malades qui sont renvoyés dans ces villes.

À l'extérieur du Baffin Regional Hospital, des services de consultation externe et d'urgence 24 heures sur 24 sont offerts par les 25 centres de santé des communautés.

Même si la dotation en infirmières et en autres professionnels de la santé n'a pas atteint les niveaux désirés, tous les services de base ont été dispensés en 2000-2001. Le Nunavut cherche à accroître les ressources dans tous les secteurs.

5.3 Accès aux services médicaux et de chirurgie dentaire assurés

Outre l'aide aux déplacements pour des raisons médicales et les initiatives en télésanté, le Nunavut a conclu des accords avec un certain nombre de régions ou d'établissements sanitaires afin de fournir des services médicaux et des services de spécialistes et d'autres professionnels de la santé en visite. Lorsque l'équipement et les services ne sont pas disponibles au Nunavut, les malades sont renvoyés dans des centres à l'extérieur du territoire. En 2000-2001, le Nunavut comptait 59 omnipraticiens et médecins de famille et 55 spécialistes et 21 dentistes (généralistes et spécialistes).

Les services spécialisés suivants sont fournis dans le cadre du programme de visites de spécialistes : ophtalmologie, orthopédie, médecine interne, oto-rhino-laryngologie, neurologie, rhumatologie, dermatologie, pédiatrie, obstétrique, physiothérapie, ergothérapie, psychiatrie et chirurgie dentaire. Des cliniques de spécialistes en visite sont ouvertes en fonction de la demande et de la disponibilité des spécialistes.

5.4 Rémunération des médecins

Trois médecins rémunérés à l'acte résident au Nunavut. Étant donné que ces médecins assument les dépenses d'un cabinet situé dans une communauté isolée, ils reçoivent 20 % de plus que les montants indiqués en annexe de la *Medical Care Act* (article 4). Les frais sont négociés entre la *N.W.T. Medical Association* et le ministère de la Santé et des Services sociaux du Nunavut. Les autres médecins travaillent à un taux quotidien établi dans un marché ou sont salariés. Les spécialistes en visite sont payés à un taux quotidien, d'après les modalités de leurs marchés.

5.5 Paiements aux hôpitaux

Le financement du Baffin Regional Hospital et des 25 centres de santé communautaire s'inscrit dans le budget du ministère au titre des activités régionales. Aucun paiement n'est versé directement à l'hôpital ou aux centres de santé communautaire.

6.0 Reconnaissance accordée aux transferts fédéraux

La reconnaissance sera accordée cette année lorsque le directeur des soins médicaux les rapports annuels pour 1999-2000 et 2000-2001 au ministère. Ces rapports seront déposés à l'assemblée législative au début de 2002.

7.0 Services complémentaires de santé

Le programme de soins à domicile aide les résidents du Nunavut qui ne sont pas pleinement en mesure de prendre soin d'eux-mêmes à la maison. Un service de visites communautaires favorise l'autonomie et soutient l'engagement des membres de la famille et de la communauté, de façon à permettre aux personnes de demeurer à leur domicile en toute sécurité. Les services comprennent les petits travaux de ménage, la préparation des repas et l'aide à la vie quotidienne.

Des soins intermédiaires sont offerts à la maison St-Theresa á Chesterfield Inlet. L'établissement fournit des soins 24 heures sur 24 et est doté d'un personnel professionnel et paraprofessionnel complet. Il fournit des services de soins infirmiers entre 7 h et 19 h. Après ces heures, seuls les services de soins personnels sont dispensés. Les consultations médicales dispensées après les heures de travail le sont par le poste de soins infirmiers communautaire.

Les services de soins infirmiers à domicile sont offerts dans les foyers pour personnes âgées d'Iqaluit et d'Arviat. Ces établissements fournissent le niveau le plus élevé de soins de longue durée au Nunavut, des services de soins complémentaires aux malades chroniques aux services de soins actifs (niveaux 4 et 5). Les malades nécessitant des soins actifs sont transférés à l'hôpital le plus près.

L'utilisation des services de télésanté représente une étape importante qui a permis d'améliorer l'accès aux services hospitaliers, médicaux, sanitaires et sociaux. Des projets pilotes sont en cours dans cinq communautés. Jusqu'à maintenant, la télésanté a été utilisée pour le counselling en santé mentale, les visites familiales et les visites prénatales et postnatales. Le but à long terme est d'intégrer la télésanté au système de prestation de soins primaires, de faciliter l'accès à une gamme plus vaste d'options de service destinés aux résidents, aux fournisseurs et aux communautés de même que d'utiliser les ressources en place plus efficacement. Notre proposition approuvée dans le cadre du Programme de partenariats pour l'infostructure canadienne de la santé (PPICS) permettra au Nunavut d'offrir des services de télésanté à dix autres communautés d'ici les deux prochaines années.

Annexe A – Statistiques sur les régimes d'assurance-santé provinciaux et territoriaux

Introduction

Le but de la présente annexe est de placer en contexte l'administration et l'application de la *Loi canadienne sur la santé* et d'offrir une perspective nationale sur les tendances qu'affichent la prestation et le financement des services de santé assurés visés par la *Loi*.

L'annexe renferme des données statistiques sur les coûts et l'utilisation des services hospitaliers, médicaux et de chirurgie dentaire assurés pour chaque province et territoire pour cinq exercices consécutifs (se terminant le 31 mars) : 1996-1997, 1997-1998, 1998-1999, 1999-2000 et 2000-2001.

Cette année, l'annexe consacrée aux statistiques renferme des données sur les personnes inscrites aux régimes d'assurance-santé, sur le nombre de médecins non participants et le nombre de médecins ayant opté pour le retrait du régime d'assurance-santé ainsi que des statistiques sur les services médicaux fournis à l'extérieur du pays.

Toute l'information a été transmise par des fonctionnaires provinciaux ou territoriaux. En vue d'assurer la cohérence des rapports, on a fourni aux gouvernements provinciaux et territoriaux un guide de l'utilisateur exposant la manière de transmettre l'information. Le guide de l'utilisateur a été préparé en consultation avec des représentants de chaque province et territoire.

Bien que nous nous soyons efforcés de saisir les données de façon uniforme, des différences existent quant à la façon que les provinces et les territoires ont de transmettre les données sur leurs programmes et services de soins de santé. Il faut donc éviter de comparer les provinces et les territoires.

L'annexe est organisée de la même manière que les descriptions des régimes d'assurance-santé provinciaux et territoriaux. Il n'y a pas de section pour le Québec, car la province a choisi de ne pas présenter l'information de la manière et dans les détails demandés par Santé Canada.

Organisation de l'information

Pour chaque province et territoire, l'information est organisée en fonction des huit sous-catégories décrites ci-après. Dans certains cas, les données n'étaient pas encore disponibles, et on a fourni des estimations. Dans d'autres cas, aucune information n'était disponible ou, encore, les statistiques demandées ne s'appliquaient pas à une province ou à un territoire particulier.

Pour un exposé plus détaillé de certaines des données contenues dans les tableaux, veuillez consulter le chapitre 2 de la présente publication, intitulé *Les Régimes d'assurance-santé des provinces et des territoires en 2000-2001*.

Inscrits

Les statistiques présentées dans cette section concernent le nombre de résidents inscrits au régime d'assurance-santé de la province ou du territoire.

Services hospitaliers fournis dans la province ou le territoire

Les statistiques présentées dans les sections 2 à 13 concernent la fourniture de services hospitaliers assurés dans chaque province ou territoire, à ses résidents et à des visiteurs provenant d'autres provinces ou territoires.

Les détails portent sur le nombre d'établissements par type de soins fournis, le nombre de lits, le nombre de radiations, la durée moyenne de séjour, les paiements totaux par catégorie de soins offerts dans la province, le coût moyen par visite et par type de soins, le nombre d'établissements privés à but lucratif et le nombre de paiements à ces derniers.

Services hospitaliers fournis à l'extérieur de la province ou du territoire (au Canada)

Cette section présente les statistiques concernant les services hospitaliers assurés qui sont fournis à l'extérieur de la province ou du territoire d'origine d'une personne qui voyage dans d'autres parties du Canada et qui sont payés par cette province ou ce territoire. L'information rapportée comprend le nombre total de demandes de paiement pour des services médicaux assurés fournis dans une autre province ou territoire, les paiements totaux effectués et le taux de paiement moyen.

Services hospitaliers fournis à l'extérieur du pays

Les services hospitaliers fournis à l'extérieur du pays représentent les coûts d'hospitalisation d'une personne qui voyage à l'extérieur du Canada, lesquels coûts sont payés par sa province ou son territoire d'origine. Les statistiques présentées dans cette section sont les mêmes que celles qui ont trait aux services hospitaliers fournis à l'extérieur de la province ou du territoire.

Services de chirurgie dentaire fournis dans la province ou le territoire

L'information fournie dans cette section décrit les services de chirurgie dentaire assurés fournis dans chaque province et territoire. Elle comprend le nombre de professionnels participants (dentistes, chirurgiens-dentistes et chirurgiens stomatologistes), le nombre de services fournis, les paiements totaux effectués au cours de l'exercice et le paiement moyen par service.

Services médicaux fournis dans la province ou le territoire

Les statistiques présentées dans cette section concernent les services médicaux assurés fournis aux résidents de chaque province ou territoire et aux visiteurs provenant d'autres régions du Canada.

Les détails portent sur le nombre de médecins participant au régime d'assurance-santé provincial ou territorial, le nombre de médecins non participants ou ayant opté pour le retrait du régime, le nombre de services assurés fournis, les paiements totaux effectués aux médecins par catégorie de médecins et par catégorie de services et le taux de paiement moyen par service médical assuré.

Services médicaux fournis à l'extérieur de la province ou du territoire (au Canada)

Cette section concerne les services médicaux qui sont payés par une province ou territoire à une autre province ou territoire pour ses résidents en voyage. Les statistiques portent notamment sur le nombre de services payés, les paiements totaux effectués et le taux de paiement moyen par service.

Services médicaux fournis à l'extérieur du pays

Les services médicaux fournis à l'extérieur du pays représentent les coûts des soins médicaux fournis à une personne qui voyage à l'extérieur du Canada, lesquels coûts sont payés par sa province ou son territoire d'origine. Les statistiques présentées dans cette section sont les mêmes que celles qui ont trait aux services médicaux fournis à l'extérieur de la province ou du territoire.

Terre-Neuve et Labrador

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	non disponible	635 835 [1]	622 744	618 118 [2]	616 944 [3]

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		33	33	33	33	32
b. soins de longue durée		0	0	0	0	0
c. soins de réadaptation		0	0	0	0	0
d. services diagnostiques aux malades externes		0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)		0	0	0	0	0
f. autres		0	0	0	0	0
g. nombre total d'établissements		33	33	33	33	32
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		1 860	1 842	1 814	1 807	non disponible
b. soins de longue durée		0	0	0	0	0
c. soins de réadaptation		38	38	62	57	non disponible
d. services diagnostiques aux malades externes		0	0	0	0	0
e. autres		0	0	0	0	0
f. nombre total de lits dotés en personnel		1 898	1 880	1 876	1 864	non disponible
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		1 860	1 842	1 814	1 807	non disponible
b. soins de longue durée		0	0	0	0	0
c. soins de réadaptation		38	38	62	57	non disponible
d. services diagnostiques aux malades externes		0	0	0	0	0
e. autres		0	0	0	0	0
f. nombre total de lits approuvés		1 898	1 880	1 876	1 864	non disponible

[1] Les données datent du 31 décembre 1997.

[2] Les données datent du 1er mars 2000.

[3] Les données datent du 11 avril 2001.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5 Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (#) :					
a. soins actifs	68 766	67 385	68 729	66 828	non disponible
b. soins de longue durée	0	0	0	0	0
c. soins de réadaptation	108	54	227	272	non disponible
d. services diagnostiques aux malades externes	0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)	0	0	0	0	0
f. en attente d'un autre type de soins	0	0	0	0	0
g. nouveau-nés	0	0	0	0	0
h. autres	0	0	0	0	0
i. nombre total de radiations	68 874	67 439	68 956	67 100	non disponible
6 Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (# de jours) :					
a. soins actifs	8,0	7,9	7,5	7,4	non disponible
b. soins de longue durée	0,0	0,0	0,0	0,0	0,0
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. nouveau-nés	0,0	0,0	0,0	0,0	0,0
e. autres	0,0	0,0	0,0	0,0	0,0
7 Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement ($) :					
a. soins actifs	431 336 662 [4]	441 408 824 [4]	457 065 782 [4]	509 018 766 [4]	537 428 824 [4]
b. soins de longue durée	0	0	0	0	0
c. soins de réadaptation	0	0	0	0	0
d. services diagnostiques aux	0	0	0	0	0
e. services de chirurgie d'un jour	0	0	0	0	0
f. autres	0	0	0	0	0
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	431 336 662 [4]	441 408 824 [4]	457 065 782 [4]	509 018 766 [4]	537 428 824 [4]

[4] Les dépenses du financement du plan provincial, représentent les coûts opérationnels seulement. Les paiements représentent le financement du plan provincial final fourni aux conseils régionaux de soins de santé dans le but de fournir des services des soins actifs assurés.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	675,0 [5]	675,0 [5]	690,0 [5]	690,0 [5]	705,0 [5]
b. soins de longue durée	0,0	0,0	0,0	0,0	0,0
c. soins de réadaptation	0,0	0,0	0,0	0,0	0,0
d. autres	0,0	0,0	0,0	0,0	0,0
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a établissements de chirurgie privés	0	1	1	1	1
b établissements d'imagerie diagnostique privés	0	0	0	0	0
c. nombre total d'établissements privés de soins de santé à but lucratif	0	1	1	1	1

[5] Tarif assuré pour résident canadien

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement :	(#)					
a. établissements de chirurgie privés		0	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés		0	0	0	0	0
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif		0	non disponible	non disponible	non disponible	non disponible
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement :	($)					
a. établissements de chirurgie privés		0	53 808	212 990	387 030	270 750
b. établissements d'imagerie diagnostique privés		0	0	0	0	0
c. total des paiements aux établissements privés de soins de santé à but lucratif		0	53 808	212 990	387 030	270 750

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	(#)	1 796	1 970	1 826	1 549	1 699
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	(#)	22 187	26 293	28 739	25 546	24 929
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	11 550 785	11 286 130	12 037 091	10 144 354	10 608 368
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	2 048 471	2 656 772	3 316 482	3 138 582	3 047 375

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	6 431,0	5 729,0	6 592,0	6 549,0	6 244,0
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	92,0	101,0	115,0	123,0	122,0

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	72	39	42	73	111
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	366	374	363	260	287
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	144 887	161 364	503 043	198 072	1 102 540
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	33 298	38 985	56 614	15 626	36 260
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	2 012,0	4 137,0	4 997,0	2 713,0	9 933,0
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	91,0	104,0	156,0	60,0	126,0

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé.	(#)	29	25	30	35	35
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants.	(#)	11 000	10 000	10 000	9 000	11 000
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés.	($)	335 000	309 000	374 000	354 000	389 000
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés.	($)	30,2	32,5	38,3	38,7	35,1

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : [6]	(#)					
a. omnipraticiens		non disponible	non disponible	non disponible	432 [7]	437 [7]
b. spécialistes		non disponible	non disponible	non disponible	480 [7]	485 [7]
c. autres		non disponible	non disponible	non disponible	sans objet	sans objet
d. total		non disponible	non disponible	non disponible	912 [7]	922 [7]
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		0	0	0	0	0
b. spécialistes		0	0	0	0	0
c. autres		0	0	0	0	0
d. total		0	0	0	0	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		0	0	0	0	0
b. spécialistes		0	0	0	0	0
c. autres		0	0	0	0	0
d. total		0	0	0	0	0

[6] Exclut les médecins qui ne pratiquent plus.

[7] Total salarié et rémunération à l'acte.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) : (#)					
a. omnipraticiens	2 783 000	2..623,000	2 471 000	2 489 000	2 340 000
b. spécialistes	2 206 000	2 407 000	2 440 000	2 443 000	2 318 000
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	4 989 000	5 030 000	4 911 000	4 932 000	4 657 000
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	3 257 000	3 195 000	3 107 000	3 104 000	2 878 000
b. services de chirurgie	447 000	487 000	487 000	468 000	433 000
c. services de diagnostic	1 285 000	1 348 000	1 317 000	1 361 000	1 346 000
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
e. total	4 989 000	5 030 000	4 911 000	4 932 000	4 657 000
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : ($)					
a. omnipraticiens	44 392 000	40 956 000	41 521 000	42 429 000	43 251 000
b. spécialistes	61 611 000	67 314 000	71 640 000	72 780 000	73 239 000
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	106 003 000	108 270 000	. 113 161 000	115 209 000	116 490 000
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	non disponible	non disponible	non disponible	72 500	71 987
b. services de chirurgie	non disponible	non disponible	non disponible	10 923	10 834
c. services de diagnostic	non disponible	non disponible	non disponible	31 786	33 670
d. autres	non disponible	non disponible	non disponible	sans objet	sans objet
e. total	106 003 000	108 270 000	113 161 000	115 209 000	116 490 000
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	16,0	15,6	16,8	17,1	18,5
b. spécialistes	27,9	28,0	29,4	29,8	31,6
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. paiement moyen pour tous les médecins	21,3	21,5	23,0	23,4	25,0

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services :	($)					
a. services médicaux		non disponible	non disponible	non disponible	non disponible	non disponible
b. services de chirurgie		non disponible	non disponible	non disponible	non disponible	non disponible
c. services de diagnostic		non disponible	non disponible	non disponible	non disponible	non disponible
d. autres		sans objet	sans objet	sans objet	sans objet	sans objet
e. paiement moyen pour tous les services		21,3	21,5	23,0	23,4	25,0

Services médicaux rendus hors province ou territoire (au Canada)						
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada).	(#)	155 000	163 000	171 000	161 000	173 000
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)	3 920 000	4 346 000	4 241 000	4 327 000	4 562 000
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)	25,4	26,6	24,8	28,4	26,4

Services médicaux rendus à l'étranger						
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés.	(#)	3 000	4 000	4 000	4 000	6 000
43. Total des paiements pour des services médicaux assurés fournis à l'étranger.	($)	76 000	94 000	65 000	107 000	424 000
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger	($)	23,5	22,4	17,3	19,6	70,2

Île-du-Prince-Édouard

Personnes inscrites					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars (#)	122 867	126 124	130 004	134 006	138 205

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement : (#)					
a. soins actifs	7	7	7	7	7
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
g. nombre total d'établissements	7	7	7	7	7
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits : (#)					
a. soins actifs	470	470	470	470	470
b. soins de longue durée	57	57	57	57	57
c. soins de réadaptation	20	20	20	20	20
d. services diagnostiques aux malades externes	19	19	19	19	19
e. autres	sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits dotés en personnel	566	566	566	566	566
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits : (#)					
a. soins actifs	470	470	470	470	470
b. soins de longue durée	57	57	57	57	57
c. soins de réadaptation	20	20	20	20	20
d. services diagnostiques aux malades externes	19	19	19	19	19
e. autres	sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits approuvés	566	566	566	566	566

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	18 047	18 626	18 644	17 796	18 280
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	336	347	377	360	329
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	6 295	5 911	6 250	6 186	non disponible
f. en attente d'un autre type de soins	non disponible	non disponible	non disponible	non disponible	267
g. nouveau-nés	non disponible	non disponible	non disponible	non disponible	1 363
h. autres	sans objet	sans objet	sans objet	sans objet	sans objet
i. nombre total de radiations	24 678	24 884	25 271	24 342	20 239
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs	8,2	8,1	7,9	8,4	8,2
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	18,0	19,0	19,0	18,0	20,0
d. nouveau-nés	non disponible	non disponible	non disponible	non disponible	non disponible
e. autres	sans objet	sans objet	sans objet	sans objet	sans objet
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs	95 100 000	94 800 000	101 600 000	104 000 000	106 774 200
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	95 100 000	94 800 000	101 600 000	104 000 000	106 774 200

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	642,6	628,4	589,8	695,7	non disponible
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total d'établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#) :					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement ($) :					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. total des paiements aux établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) (#).	1 893	1 904	2 279	1 812	non disponible [1]
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) (#).	11 478	13 341	16 457	14 428	non disponible [1]
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) ($).	11 900 000	11 300 000	12 300 000	10 600 000	non disponible [1]
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) ($).	1 400 000	1 700 000	2 600 000	2 300 000	non disponible [1]

[1] Le Nouveau-Brunswick et la Nouvelle-Écosse ont changé leurs systèmes. Les données hors province et à l'étranger ne sont pas disponibles.

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	6 286,0	5 935,0	5 397,0	5 850,0	non disponible [1]
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	122,0	127,0	158,0	160,0	non disponible [1]

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	35	48	27	21	non disponible
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	157	211	102	106	non disponible
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	121 000	119 400	50 100	53 800	non disponible
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	41 500	76 600	11 700	21 700	non disponible
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	3 457,0	2 486,0	1 856,0	2 561,0	non disponible
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	264,0	363,0	115,0	205,0	non disponible

[1] Le Nouveau-Brunswick et la Nouvelle-Écosse ont changé leurs systèmes. Les données hors province et à l'étranger ne sont pas disponibles.

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé. (#)	1	1	2	2	2
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants. (#)	418	411	400	176	145
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés. ($)	49 900	50 200	52 700	37 600	53 100
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés. ($)	119,0	122,0	132,0	214,0	366,0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	92	97	98	99	101
b. spécialistes	80	75	72	74	75
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	172	172	170	173	176
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	sans objet	sans objet	sans objet	sans objet	sans objet
b. spécialistes	sans objet	sans objet	sans objet	sans objet	sans objet
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	sans objet	sans objet	sans objet	sans objet	sans objet
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	sans objet	sans objet	sans objet	sans objet	sans objet
b. spécialistes	sans objet	sans objet	sans objet	sans objet	sans objet
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	sans objet	sans objet	sans objet	sans objet	sans objet

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (#) (rémunération à l'acte) :					
a. omnipraticiens	838 527	834 740	869 320	848 816	861 112
b. spécialistes	386 714	394 912	422 483	415 130	409 917
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	1 225 241	1 229 652	1 291 803	1 263 946	1 271 029
34. Nombre de services médicaux assurés, par catégorie de services (#) :					
a. services médicaux	132 979	141 594	158 836	154 930	152 796
b. services de chirurgie	139 338	138 667	146 186	144 947	143 940
c. services de diagnostic	114 397	114 651	117 461	115 253	113 181
d. autres	838 527	834 740	869 320	848 816	861 112
e. total	1 225 241	1 229 652	1 291 803	1 263 946	1 271 029
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins ($) :					
a. omnipraticiens	14 400 000	14 800 000	15 000 000	15 700 000	15 800 000
b. spécialistes	15 300 000	15 600 000	16 200 000	17 100 000	17 200 000
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	29 700 000	30 400 000	31 200 000	32 800 000	33 000 000
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services ($) :					
a. services médicaux	5 600 000	5 900 000	6 200 000	6 600 000	6 500 000
b. services de chirurgie	8 000 000	8 000 000	8 300 000	8 800 000	8 900 000
c. services de diagnostic	1 700 000	1 700 000	1 700 000	1 700 000	1 800 000
d. autres	sans objet	sans objet	sans objet	sans objet	15 800 000
e. total	29 700 000	30 400 000	31 200 000	32 800 000	33 000 000
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins ($) :					
a. omnipraticiens	17.0	18.0	17.0	18.0	18.0
b. spécialistes	40.0	40.0	38.0	41.0	42.0
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. paiement moyen pour tous les médecins	24.0	25.0	24.0	26.0	26.0

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38 Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services	**($)**					
a services médicaux		42,0	42,0	39,0	43,0	43,0
b services de chirurgie		57,0	58,0	57,0	61,0	62,0
c services de diagnostic		15,0	15,0	15,0	15,0	15,0
d autres		sans objet	sans objet	sans objet	sans objet	sans objet
e paiement moyen pour tous les services		24,0	25,0	24,0	26,0	26,0

Services médicaux rendus hors province ou territoire (au Canada)						
39 Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada)	**(#)**	57 904	58 667	56 192	56 084	non disponible [1]
40 Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada)	**($)**	2 650 000	2 780 000	3 090 000	3 080 000	non disponible [1]
41 Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada)	**($)**	46,0	47,0	55,0	55,0	non disponible [1]

Services médicaux rendus à l'étranger						
42 Nombre de services médicaux assurés fournis à l'étranger qui ont été payés	**(#)**	907	1 242	807	666	non disponible [1]
43 Total des paiements pour des services médicaux assurés fournis à l'étranger	**($)**	35 805	52 874	25 495	38 274	non disponible [1]
44 Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger	**($)**	39,0	42,0	31,0	57,0	non disponible [1]

[1] Le Nouveau-Brunswick et la Nouvelle-Écosse ont changé leurs systèmes. Les données hors province et à l'étranger ne sont pas disponibles.

Nouvelle-Écosse

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	930 805	933 324	937 587	944 487	947 963

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		36	36	36	36	36
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)		sans objet	sans objet	sans objet	sans objet	sans objet
f. autres		sans objet	sans objet	sans objet	sans objet	sans objet
g. nombre total d'établissements		36	36	36	36	36
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		3 375 [1]	3 226 [1]	3 233 [1]	3 135 [1]	3 044 [1]
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits dotés en personnel		3 375	3 226	3 233	3 135	3 044
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits approuvés		sans objet	sans objet	sans objet	sans objet	sans objet

[1] Comprend les soins de réadaptation

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	109 722	108 536	106 954	104 509	94 745
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	897 [2]	944 [2]	855 [2]	792 [2]	800 [2]
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	77 432	86 014	89 046	93 700	96 832
f. en attente d'un autre type de soins	916	1 422	1 690	2 002	2 064
g. nouveau-nés	10 474	9 951	9 675	9 607	9 038
h. autres	non disponible	non disponible	133	135	150
i. nombre total de radiations	198 525 [3]	205 445 [3]	206 530 [3]	208 608 [3]	201 415 [3]
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs	7,7	8,2	7,9	8,3	8,6
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	36,7	45,6	44,8	45,0	48,6
d. nouveau-nés	3,5	3,7	3,7	3,7	3,8
e. autres	non disponible	non disponible	124,8	159,4	147,1
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : [4] ($)					
a. soins actifs	645 026 000	701 208 000	795 946 000	812 776 800	877 019 426
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	645 026 000	701 208 000	795 946 000	812 776 800	877 019 426

[2] Soins de niveau type 4.

[3] Exclut les séparations avec jours en attente d'un autre type de soins.

[4] Les $ sont versés aux établissements de soins aigus et aux ASD seulement.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	435,9	435,9	391,6	391,6	391,6
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	89,0 [5]	89,0 [5]	110,0 [5]	110,0 [5]	110,0 [5]
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	3 249,1	3 413,1	3 853,9	3 896,2	4 354,3
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	1	1	1	1	1
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total d'établissements privés de soins de santé à but lucratif	1	1	1	1	1

[5] Tarif national normalisé pour les services pour malades externes

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : ($)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. total des paiements aux établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). (#)	2 173	2 331	2 395	2 380	2 357
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). (#)	24 521	29 165	29 927	30 078	32 174
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). ($)	9 141 843	8 864 423	10 395 116	10 502 390	9 559 303
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). ($)	2 506 490	3 038 860	3 770 060	3 771 435	4 083 677

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18 Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	4 207,0	3 802,8	4 340,3	4 412,8	4 055,7
19 Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	102,2	104,2	126,0	125,4	126,9

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	non disponible	non disponible	non disponible	non disponible	non disponible
21 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	non disponible	non disponible	non disponible	non disponible	non disponible
22 Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	1 003 664	851 689	859 642	1 053 577	736 104
23 Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	non disponible	non disponible	non disponible	non disponible	non disponible
24 Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	non disponible	non disponible	non disponible	non disponible	non disponible
25 Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	non disponible	non disponible	non disponible	non disponible	non disponible

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé (#)	55	53	54	55	39
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants (#)	14 525	15 549	16 909	17 525	6 853
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés ($)	1 439 885	1 515 311	1 726 646	1 467 485	988 692
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés ($)	99,1	97,5	102,1	83,7	144,3

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins (#)					
a. omnipraticiens	non disponible	non disponible	non disponible	829	741 [6]
b. spécialistes	non disponible	non disponible	non disponible	1 095	1 016 [6]
c. autres	0	0	0	0	0
d. total	1 826	1 836	1 853	1 924	1 757 [6]
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins (#)					
a. omnipraticiens	0	0	0	0	0
b. spécialistes	0	0	0	0	0
c. autres	0	0	0	0	0
d. total	0	0	0	0	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-sante, par catégorie de médecins (#)					
a. omnipraticiens	0	0	0	0	0
b. spécialistes	0	0	0	0	0
c. autres	0	0	0	0	0
d. total	0	0	0	0	0

[6] Les chiffres sont ajustés pour afficher seulement les médecins dans chaque sous-catégorie

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte)	(#)					
a. omnipraticiens		non disponible	4 443 772	4 334 359	4 619 083	4 571 239
b. spécialistes		non disponible	1 854 669	1 794 146	1 606 842	1 576 479
c. autres		non disponible	0	0	0	0
d. total		6 298 935	6 298 441	6 128 505	6 225 925	6 147 718
34. Nombre de services médicaux assurés, par catégorie de services	(#)					
a. services médicaux		non disponible	5 980 487	5 809 644	5 908 054	4 637 320 [7]
b. services de chirurgie		non disponible	317 854	320 861	317 871	331 316 [7]
c. services de diagnostic		non disponible	1 545 203	1 544 529	1 514 011	604 275 [7]
d. autres		non disponible	0	0	0	574 778 [7]
e. total		6 854 885	7 843 544	7 675 034	7 739 936	6 147 689 [7]
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins	($)					
a. omnipraticiens		94 476 324	91 782 118	91 620 190	104 587 110	105 480 167
b. spécialistes		108 424 409	115 725 195	118 656 216	112 250 617	114 919 756
c. autres		0	0	0	0	0
d. total		202 900 733	207 507 313	210 276 406	216 837 727	220 399 923
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services	($)					
a. services médicaux		non disponible	non disponible	non disponible	non disponible	142 110 171 [7]
b. services de chirurgie		non disponible	non disponible	non disponible	non disponible	52 737 469 [7]
c. services de diagnostic		non disponible	non disponible	non disponible	non disponible	19 583 421 [7]
d. autres		non disponible	non disponible	non disponible	non disponible	5 967 370 [7]
e. total		267 449 785	296 138 155	317 320 281	350 091 235	220 398 370 [7]
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins	($)					
a. omnipraticiens		non disponible	20,7	21,1	22,6	23,1
b. spécialistes		non disponible	62,4	66,1	69,9	72,9
c. autres		0,0	0,0	0,0	0,0	0,0
d. paiement moyen pour tous les médecins		32,2	32,9	34,3	34,8	35,9

[7] Rémunération à l'acte seulement

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services : [7]	($)					
a. services médicaux		non disponible	non disponible	non disponible	non disponible	30,6
b. services de chirurgie		non disponible	non disponible	non disponible	non disponible	183,7
c. services de diagnostic		non disponible	non disponible	non disponible	non disponible	32,4
d. autres		non disponible	non disponible	non disponible	non disponible	10,4
e. paiement moyen pour tous les services		39,0	37,8	41,3	45,2	35,9

Services médicaux rendus hors province ou territoire (au Canada) [8]						
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada).	(#)	non disponible	non disponible	non disponible	non disponible	180 299
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)	non disponible	non disponible	non disponible	non disponible	4 766 189
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)	non disponible	non disponible	non disponible	non disponible	26,4

Services médicaux rendus à l'étranger [8]						
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés.	(#)	non disponible	non disponible	non disponible	non disponible	2 541
43. Total des paiements pour des services médicaux assurés fournis à l'étranger.	($)	non disponible	non disponible	non disponible	non disponible	98 461
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger.	($)	non disponible	non disponible	non disponible	non disponible	38,7

[7] Rémunération à l'acte seulement.

[8] Des paiements s'élevant à 123 448 $ ne sont pas inclus dans les questions 39 à 44 étant donné que la répartition entre les services assurés hors province et hors territoire et à l'étranger pour la somme versée n'est pas connue. De plus, le nombre de services n'est pas connu.

Nouveau-Brunswick

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	747 173	742 218	735 510	739 336	738 598

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos) par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		31	31	31	31	31
b. soins de longue durée		0	0	0	0	0
c. soins de réadaptation		1	1	1	1	1
d. services diagnostiques aux malades externes		0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)		0	0	0	0	0
f. autres		0	0	0	0	0
g. nombre total d'établissements		32	32	32	32	32
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée		non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation		non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes		non disponible	non disponible	non disponible	non disponible	non disponible
e. autres		non disponible	non disponible	non disponible	non disponible	non disponible
f. nombre total de lits dotés en personnel		non disponible	non disponible	non disponible	non disponible	non disponible
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		3 036	3 036	3 036	3 036	3 036
b. soins de longue durée		397	397	397	397	397
c. soins de réadaptation		20	20	20	20	20
d. services diagnostiques aux malades externes		0	0	0	0	0
e. autres		0	0	0	0	0
f. nombre total de lits approuvés		3 453	3 453	3 453	3 453	3 453

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	110 549	110 865	109 542	108 353	102 465
b. soins de longue durée	2 423	2 280	2 398	2 281	1 887
c. soins de réadaptation	406	457	411	444	465
d. services diagnostiques aux malades externes	0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)	45 175	44 597	42 962	46 287	46 345
f. en attente d'un autre type de soins	231	246	307	308	342
g. nouveau-nés	8 347	8 050	7 939	7 778	7 455
h. autres	0	0	0	0	0
i. nombre total de radiations	167 131	160 495	163 559	165 451	158 959
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs	6,3	6,6	6,8	6,8	7,1
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	41,9	39,1	47,3	41,3	41,2
d. nouveau-nés	non disponible	non disponible	non disponible	non disponible	non disponible
e. autres	non disponible	non disponible	non disponible	non disponible	non disponible
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	596 141 800	629 964 593	639 764 216	674 487 768	non disponible

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement (#)					
a établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total d'établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : ($)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. total des paiements aux établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) (#)	3 827 pts / 28 086 jours	3 566 pts / 24 993 jours	3 768 pts / 24 915 jours	3 900 pts / 25 655 jours	4 130 pts / 26 572 jours
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) (#)	31 229	31 684	36 081	32 796	35 834
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) ($)	24 836 405	21 515 090	21 863 730	22 473 974	21 561 907
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) ($)	3 108 218	3 295 272	4 374 860	4 235 429	4 702 219

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	884,3	860,8	877,5	876,0	811,5
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	99,5	104,0	121,3	129,1	131,2

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	231 pts / 1,110 jours	190 pts / 788 jours	145 pts / 661 jours	212 pts / 1,691 jours	166 pts / 1 096 jours
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	1 318	881	395	524	639
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	1 106 445	385 548	150 403	487 760	458 759
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	159 197	101 585	85 443	105 783	180 712
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	996,8	489,3	227,5	288,4	418,6
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	120,8	115,3	216,3	201,9	282,8

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26 Nombre de dentistes qui participent au régime d'assurance-santé (#)	12	14	17	12	16
27 Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants (#)	602	632	790	751	1 004
28 Total des paiements aux dentistes pour des services de chirurgie dentaire assurés ($)	96 683	119 524	132 577	136 491	189 777
29 Paiement moyen (par service) pour des services de chirurgie dentaire assurés ($)	160.6	189.1	167.8	181.7	189.0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30 Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins (#)					
a omnipraticiens	575	581	619	629	645
b spécialistes	678	682	709	721	710
c autres	non disponible	non disponible	non disponible	non disponible	non disponible
d total	1 253	1 263	1 328	1 350	1 355
31 Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins (#)					
a omnipraticiens	0	0	0	0	0
b spécialistes	0	0	0	0	0
c autres	0	0	0	0	0
d total	0	0	0	0	0
32 Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins (#)					
a omnipraticiens	0	0	0	0	0
b spécialistes	0	0	0	0	0
c autres	0	0	0	0	0
d total	0	0	0	0	0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33 Nombre de services médicaux assurés, par catégorie de médecins (#) (rémunération à l'acte)					
a omnipraticiens	3 626 061	3 625 877	3 692 566	3 721 782	3 668 781
b spécialistes	2 423 736	2 479 186	2 551 663	2 612 744	1 568 927 [1]
c autres	non disponible	non disponible	non disponible	non disponible	non disponible
d total	6 049 797	6 105 063	6 244 229	6 334 526	5 237 708
34 Nombre de services médicaux assurés, par catégorie de services (#)					
a services médicaux	684 943	686 896	729 303	739 911	728 947
b services de chirurgie	805 335	827 458	828 626	852 725	839 980
c services de diagnostic	933 458 [2]	964 832 [2]	993 234 [2]	1 020 108 [2]	non disponible
d autres	3 626 061	3 625 877	3 692 566	3 721 782	3 668 781
e total	6 049 797	6 105 063	6 244 229	6 334 526	5 237 708
35 Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins ($)					
a omnipraticiens	73 575 982	74 575 504	77 851 628	77 958 130	78 139 070
b spécialistes	96 165 584	100 834 441	104 752 866	111 554 173	88 908 789 [1]
c autres	non disponible	non disponible	non disponible	non disponible	non disponible
d total	169 741 566	175 409 945	182 604 494	189 512 303	167 047 859
36 Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services ($)					
a services médicaux	36 116 218	37 548 393	40 384 442	41 795 791	41 068 744
b services de chirurgie	44 697 549	46 574 724	46 871 179	48 732 272	47 840 045
c services de diagnostic	15 351 817 [2]	16 711 324 [2]	17 497 245 [2]	21 026 109 [2]	non disponible
d autres	73 575 982 [3]	74 575 504 [3]	77 851 628 [3]	77 958 130 [3]	78 139 070 [3]
e total	169 741 566	175 409 945	182 604 494	189 512 302	167 047 859
37 Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins ($)					
a omnipraticiens	20.3	20.6	21.1	20.9	21.3
b spécialistes	39.7	40.7	41.1	42.7	56.7
c autres	non disponible	non disponible	non disponible	non disponible	non disponible
d paiement moyen pour tous les médecins	28.7	28.7	29.2	29.9	31.9

[1] Les données en radiologie sont incomplètes pour l'année fiscale 2000-2001

[2] Radiologie seulement

[3] Comprend les omnipraticiens

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services ($)					
a. services médicaux	52,7	54,7	55,3	56,5	56,3
b. services de chirurgie	55,5	56,3	56,6	57,1	57,0
c. services de diagnostic	16,4 [2]	17,3 [2]	17,6 [2]	20,6 [2]	non disponible
d. autres	20,3 [3]	20,6 [3]	21,1 [3]	20,9 [3]	21,3 [3]
e. paiement moyen pour tous les services	28,1	28,7	29,2	29,9	31,9

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	132 873	153 230	140 375	137 950	160 119
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	4 665 617	6 186 476	5 684 969	6 050 729	7 697 923
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	35,1	40,4	40,5	43,9	48,1

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	6 675	7 283	3 835	4 554	4 200
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	321 754	366 996	223 066	356 128	362 709
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger. ($)	48,2	50,4	58,2	78,2	86,4

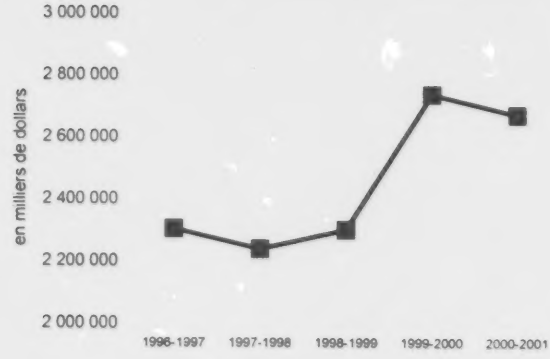
[2] Radiologie seulement.

[3] Comprend les omnipraticiens.

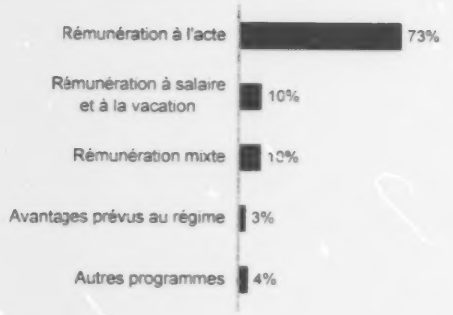
Québec[1]

Services médicaux	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
	(en milliers de dollars)				
Régime d'assurance maladie	2 209 354	2 145 535	2 203 461	2 634 945	2 562 034
Rémunération à l'acte	1 870 783	1 789 854	1 820 968	2 173 993	1 957 201
Spécialistes	1 131 647	1 081 637	1 090 532	1 257 148	1 105 463
Omnipraticiens	672 547	636 807	657 450	841 128	774 215
Commission de la santé et de la sécurité du travail	43 461	47 533	49 935	54 249	52 822
Remboursements versés aux personnes assurées	13 992	14 790	14 135	12 473	15 826
Professionnels de la santé hors du Québec	9 136	9 087	8 916	8 995	8 875
Rémunération à salaire et à la vacation	291 039	294 761	300 447	289 919	267 658
Vacation et honoraires forfaitaires	192 028	200 312	212 843	208 119	183 217
Salaire et honoraires fixes	91 833	87 852	81 226	75 520	78 043
Commission de la santé et de la sécurité du travail	7 178	6 597	6 378	6 280	6 398
Rémunération mixte	-	-	-	72 856	258 949
Régime d'assurance maladie	-	-	-	72 234	256 732
Commission de la santé et de la sécurité du travail	-	-	-	622	2 217
Avantages prévus au régime	47 532	60 920	82 046	98 177	78 226
Mesures particulières	34 516	49 010	56 735	57 699	48 229
Assurance responsabilité professionnelle	13 016	11 910	25 311	40 478	29 997
Autres programmes	94 673	93 967	97 230	102 809	109 755
Rémunération des résidents en médecine	93 351	92 670	95 964	101 247	108 100
Autres	1 322	1 297	1 266	1 562	1 655
Total	**2 304 027**	**2 239 502**	**2 300 691**	**2 737 754**	**2 671 789**

Évolution des coûts



Répartition des coûts pour 2000-2001



[1] Le Québec a choisi de ne pas communiquer l'information sous la forme et selon les modalités requises par Santé Canada. Le tableau et les graphiques ont été reproduits tels que le Québec les a présentés à Santé Canada.

Ontario

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1 Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars	(#)	10,9 M [1]	11,2 M [1]	11,3 M [1]	11,4 M [1]	11,7 M [1]

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2 Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a soins actifs		non disponible [2]	179	157	154	150
b soins de longue durée		non disponible [2]	20	22	12	11
c soins de réadaptation		non disponible [2]	6	5	4	4
d services diagnostiques aux malades externes		non disponible [3]	non disponible [3]	non disponible [3]	non disponible [3]	non disponible [3]
e services de chirurgie d'un jour (aux malades externes)		non disponible [4]	non disponible [4]	non disponible [4]	non disponible [4]	non disponible [4]
f autres		non disponible [2]	4	4	3	3
g nombre total d'établissements		non disponible [5]	non disponible [5]	non disponible [5]	non disponible [5]	non disponible [5]
3 Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a soins actifs		26 267	24 505	23 872	24 254	25 008
b soins de longue durée		8 678	8 149	7 787	7 505	7 455
c soins de réadaptation		1 875	1 815	1 822	1 975	2 137
d services diagnostiques aux malades externes		non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]
e autres		non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]
f nombre total de lits dotés en personnel		non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]	non disponible [6]
4 Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a soins actifs		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]
b soins de longue durée		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]
c soins de réadaptation		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]
d services diagnostiques aux malades externes		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]
e autres		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]
f nombre total de lits approuvés		non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]	non disponible [7]

1 M = millions.

2 Données historiques non disponibles.

3 L'Ontario ne possède pas d'établissements dans ces catégories. Ces types d'établissements sont privés et tous les services assurés sont couverts par la province.

4 Pour les chirurgies d'un jour, le nombre de cas est recensé mais pas le nombre de civières. Cependant, les unités de soins actifs, de longue durée et de réadaptation recensent le nombre de lits et les radiations.

5 Le total n'est pas disponible puisque certaines des données de la liste ne le sont pas non plus.

6 Les chiffres concernant les autres types de lits ne sont pas fournis séparément; ils sont intégrés dans les rapports sur les lits pour soins actifs, soins prolongés et soins de réadaptation.

7 Non disponible - il n'y a pas de fichier central pour ce type de données.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (#)					
a. soins actifs	1 074 967	1 041 004	1 131 333	1 007 464	1 004 042
b. soins de longue durée	17 321	18 426	17 165	18 943	19 777
c. soins de réadaptation	17 399	18 513	188 865	20 837	20 236
d. services diagnostiques aux malades externes	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]
e. services de chirurgie d'un jour (aux malades externes)	814 595	879 826	896 833	943 045	983 916
f. en attente d'un autre type de soins	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]
g. nouveau-nés	140 746	137 114	134 505	134 136	130 062
h. autres	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]	non disponible [8]
i. nombre total de radiations	non disponible [5]	non disponible [5]	non disponible [5]	non disponible [5]	non disponible [5]
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (# de jours)					
a. soins actifs	6,5 [9]	6,4 [9]	6,5 [9]	6,6 [9]	7,0 [9]
b. soins de longue durée	162,1 [9]	140,8 [9]	129,1 [9]	128,9 [9]	118,1 [9]
c. soins de réadaptation	32,3	32,3	30,3	29,9	26,3
d. nouveau-nés	2,9	2,9	2,8	2,9	3,0
e. autres	non disponible [10]	non disponible [10]	non disponible [10]	non disponible [10]	non disponible [10]
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement ($)					
a. soins actifs	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
b. soins de longue durée	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
c. soins de réadaptation	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
d. services diagnostiques aux	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
e. services de chirurgie d'un jour	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
f. autres	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]	non disponible [11]
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	7,4 B [12]	6,7 B [12]	7,1 B [12]	7,5 B [12]	8,0 B [12]

5 Le total n'est pas disponible puisque certaines des données de la liste ne le sont pas non plus.

8 Non disponible - les données ne sont pas classées de la même façon. Ainsi, les autres niveaux de soins sont classés dans la même catégorie que les radiations des soins actifs.

9 Données révisées - Auparavant, les données sur la durée du séjour pour les soins actifs n'incluaient pas les patients des services psychiatriques - Les données pour les soins de longue durée ont été modifiées en fonction des méthodes de rapport internes.

10 Les autres types de soins ne sont pas classés en catégories distinctes.

11 a) Les établissements en Ontario tendent à être mixtes (soins actifs et de longue durée, soins de longue durée et de réadaptation) avec une minorité du genre patient unique.

b) Le classement par type d'établissement ne donne qu'un échantillon restreint, faussant les montants réellement dépensés pour les lits de soins de longue durée et de réadaptation.

12 B = milliards.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins ($)					
a. soins actifs	626,0	654,0	691,0	761,0	non disponible [13]
b. soins de longue durée	253,0	266,0	274,0	287,0	non disponible [13]
c. soins de réadaptation	363,0	369,0	385,0	436,0	non disponible [13]
d. autres	non disponible [10]	non disponible [10]	non disponible [10]	non disponible [10]	non disponible [13]
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins ($)					
a. soins actifs	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
b. soins de longue durée	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
c. soins de réadaptation	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
d. services diagnostiques aux malades externes	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
e. services de chirurgie d'un jour (aux malades externes)	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
f. autres	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins ($)					
a. soins actifs	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
b. soins de longue durée	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
c. soins de réadaptation	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
d. autres	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]	non disponible [14]
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement (#)					
a. établissements de chirurgie privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
b. établissements d'imagerie diagnostique privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
c. nombre total d'établissements privés de soins de santé à but lucratif	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]

[10] Les autres types de soins ne sont pas classés en catégories distinctes.

[13] Ces données n'étaient pas encore disponibles lors de la production de ce rapport.

[14] Non disponible - l'exactitude des données étant douteuse, comme l'est celle des calculs, ces derniers ne peuvent pas être justifiés ni diffusés.

a) La établissements en Ontario tendent à être mixtes (soins actifs et de longue durée, soins de longue durée et de réadaptation) avec une minorité du genre patient unique.

b) Le division par type d'établissements réduit l'échantillonnage et minimise grandement le nombre d'activités liées aux patients externes recevant des soins prolongés et des soins de réadaptation.

c) Les amalgamations au cours de cette période contribuent également à la variabilité des données, surtout lorsqu'elles sont classées par activité principale.

[15] Non disponible - il n'y a pas de système unique de collecte de ces données au Ministère.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12 Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#) :					
a établissements de chirurgie privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
b établissements d'imagerie diagnostique privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
c nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
13 Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement ($) :					
a établissements de chirurgie privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
b établissements d'imagerie diagnostique privés	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]
c total des paiements aux établissements privés de soins de santé à but lucratif	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]	non disponible [15]

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) (#)	6 494	8 004	8 431	9 031	9 540
15 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) (#)	80 263	102 504	104 398	155 648	161 882
16 Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) ($)	27,9 M	36,2 M	32,8 M	41,3 M	39,9 M
17 Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) ($)	8,3 M	10,7 M	13,3 M	18,7 M	22,0 M

[15] Non disponible - il n'y a pas de système unique de collecte de ces données au Ministère

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18 Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	4 296,0	4 523,0	3 890,0	4 573,0	4 182,0
19 Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	103,0	104,0	127,0	120,0	136,0

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	30 688	26 211	24 141	20 657	20 503
21 Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	inclus dans #20	inclus dans #20	inclus dans #20	inclus dans #20	inclus dans #20
22 Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	31,6 M	25,0 M	21,4 M	17,0 M	18,8 M
23 Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	inclus dans #22	inclus dans #22	inclus dans #22	inclus dans #22	inclus dans #22
24 Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	1 030,0	954,0	886,0	823,0	918,0
25 Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	inclus dans #24	inclus dans #24	inclus dans #24	inclus dans #24	inclus dans #24

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26 Nombre de dentistes qui participent au régime d'assurance-santé	(#)	367	366	350	350 [16]	357
27 Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants	(#)	67 156	69 163	70 658	69 400	71 660
28 Total des paiements aux dentistes pour des services de chirurgie dentaire assurés	($)	7,8 M	7,9 M	7,9 M	8,1 M	8,2 M
29 Paiement moyen (par service) pour des services de chirurgie dentaire assurés	($)	116,2	114,2	111,8	116,7	115,2

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30 Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins :	(#)					
a omnipraticiens		10 475 [17]	10 319	10 221	10 227	10 281
b spécialistes		9 825	9 944	9 994	10 284	10 392
c autres		non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]
d total		20 300	20 263	20 215	20 511	20 673
31 Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a omnipraticiens		33	29	26	25	25
b spécialistes		221	209	196	188	177
c autres		non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]
d total		254	238	222	213	202
32 Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a omnipraticiens		non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]
b spécialistes		non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]
c autres		non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]
d total		non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]	non disponible [19]

[16] Bien que 350 dentistes participent au régime d'assurance-santé, 700 sont inscrits à la Corporate Provider Database (banque de données des entreprises fournissant des services).

[17] a) Source de toutes les données sur les services médicaux assurés : Ontario Statistical Reporting System (système de présentation des statistiques du régime d'assurance-santé de l'Ontario), d'avril 1996 à mars 2000.

b) Ces statistiques, qui proviennent du Ontario Statistical Reporting System, représentent le nombre de médecins qui sont payés à l'acte. Les médecins inscrits ne facturent pas tous à l'acte. Le nombre de services médicaux n'inclut pas les services de laboratoire. De plus, les soins obstétricaux sont compris dans les services médicaux.

c) Les services médicaux comprennent les unités de temps des assistants et anesthésistes, et la portion concernant le diagnostic comprend les composantes professionnelle et technique comptées séparément.

d) Les statistiques reflètent l'état de la situation à la fin de mars de chaque exercice financier.

[18] Tous les médecins sont classés dans les catégories omnipraticiens ou spécialistes, et selon qu'il s'agit de services médicaux, chirurgicaux ou de diagnostic.

[19] L'Ontario ne compte aucun médecin non participant, seulement des médecins qui s'en sont retirés et qui sont inclus dans l'élément 31.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (#) (rémunération à l'acte) :					
a. omnipraticiens	82,0 M	83,6 M	80,4 M	79,6 M	79,7 M
b. spécialistes	85,9 M	90,8 M	89,9 M	91,4 M	93,6 M
c. autres	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]
d. total	167,9 M	174,4 M	170,3 M	171,0 M	173,3 M
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	84,1 M	85,3 M	84,2 M	84,1 M	82,9 M
b. services de chirurgie	21,4 M	22,2 M	21,6 M	22,0 M	22,3 M
c. services de diagnostic	62,4 M	66,8 M	64,4 M	64,8 M	68,1 M
d. autres	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]
e. total	167,9 M	174,3 M	170,2 M	170,9 M	173,3 M
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : ($)					
a. omnipraticiens	1 688,3 M	1 722,7 M	1 676,9 M	1 725,2 M	1 734,1 M
b. spécialistes	2 443,5 M	2 618,6 M	2 587,2 M	2 699,2 M	2 824,3 M
c. autres	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]
d. total	4 131,8 M	4 341,3 M	4 264,1 M	4 424,4 M	4 558,4 M
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	2 593,9 M	2 664,5 M	2 605,6 M	2 678,6 M	2 699,8 M
b. services de chirurgie	586,2 M	616,0 M	608,5 M	633,8 M	670,8 M
c. services de diagnostic	951,7 M	1 060,8 M	1 050,1 M	1 112,0 M	1 187,8 M
d. autres	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]
e. total	4 131,8 M	4 341,3 M	4 264,2 M	4 424,4 M	4 558,4 M
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	20,6	20,6	20,9	21,7	21,8
b. spécialistes	28,5	28,8	28,8	29,5	30,2
c. autres	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]	non disponible [16]
d. paiement moyen pour tous les médecins	24,6	24,9	25,1	25,9	26,3

[16] Tous les médecins sont classés dans les catégories omnipraticiens ou spécialistes, et selon qu'il s'agit de services médicaux, chirurgicaux ou de diagnostic.

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services	($)					
a. services médicaux		30,8	31,2	30,9	31,8	32,6
b. services de chirurgie		27,5	27,7	28,2	28,8	30,1
c. services de diagnostic		15,2	15,9	16,3	17,2	17,5
d. autres		non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]	non disponible [18]
e. paiement moyen pour tous les services		24,6	24,9	25,1	25,9	26,3

Services médicaux rendus hors province ou territoire (au Canada)						
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada)	(#)	399 005	428 329	433 396	455 136	433 463
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada)	($)	12,9 M	12,8 M	13,3 M	14,0 M	14,3 M
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada)	($)	32,0	30,0	31,0	31,0	33,0

Services médicaux rendus à l'étranger						
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés	(#)	266 856	228 379	207 736	184 107	179 679
43. Total des paiements pour des services médicaux assurés fournis à l'étranger	($)	8,1 M	7,5 M	7,0 M	11,6 M	15,5 M
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger	($)	30,0	33,0	34,0	63,0	86,0

[18] Tous les médecins sont classés dans les catégories omnipraticiens ou spécialistes, et selon qu'il s'agit de services médicaux, chirurgicaux ou de diagnostic.

Manitoba

Personnes inscrites [1]					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1 Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars (#)	1 144 643	1 146 331	1 142 465	1 144 424	1 149 904

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2 Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement (#)					
a soins actifs	95	95	96	95	95
b soins de longue durée	4 [2]	4 [2]	4 [2]	4 [2]	3 [2]
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e services de chirurgie d'un jour (aux malades externes)	sans objet	sans objet	sans objet	sans objet	sans objet
f autres	sans objet	sans objet	sans objet	sans objet	sans objet
g nombre total d'établissements	99	99	99	99	98
3 Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits (#)					
a soins actifs	4 628	4 559	4 436	4 394	4 406
b soins de longue durée	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e autres	non disponible	non disponible	non disponible	non disponible	non disponible
f nombre total de lits dotés en personnel	non disponible	non disponible	non disponible	non disponible	non disponible
4 Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits [3] (#)					
a soins actifs	4 628	4 559	4 439	4 394	4 406
b soins de longue durée	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e autres	non disponible	non disponible	non disponible	non disponible	non disponible
f nombre total de lits approuvés	5 187	4 951	4 841	4 796	4 791

1 D'après les données de la population des résidents inscrits au régime de l'assurance-maladie du Manitoba, à partir du 1er juin

2 Comprend les soins prolongés et les soins de réadaptation

3 Nombre de lits dressés en date du 31 mars par un hôpital pour loger des patients

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5 Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (#)					
a soins actifs	139 463	136 931	136 499	132 650	127 903
b soins de longue durée	1 640	1 746	1 757	1 876	1 905
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e services de chirurgie d'un jour (aux malades externes)	99 571	107 418	111 931	115 136	116 305
f en attente d'un autre type de soins	non disponible	non disponible	non disponible	non disponible	non disponible
g nouveau-nés	15 838	14 784	14 814	14 807	14 403
h autres	non disponible	non disponible	non disponible	non disponible	non disponible
i nombre total de radiations	256 512	260 879	265 001	264 469	260 516
6 Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (# de jours)					
a soins actifs	9,3	9,3	9,5	9,7	9,9
b soins de longue durée	103,6 [2]	118,0 [2]	74,3 [2]	69,0 [2]	78,4 [2]
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d nouveau-nés	3,6	3,7	3,9	3,5	3,5
e autres	non disponible	non disponible	non disponible	non disponible	non disponible
7 Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement ($)					
a soins actifs	non disponible	non disponible	non disponible	non disponible	953 834 797
b soins de longue durée	non disponible	non disponible	non disponible	non disponible	65 153 895
c soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d services diagnostiques aux	non disponible	non disponible	non disponible	non disponible	non disponible
e services de chirurgie d'un jour	non disponible	non disponible	non disponible	non disponible	non disponible
f autres	non disponible	non disponible	non disponible	non disponible	non disponible
g total des paiements aux établissements qui fournissent des services hospitaliers assurés	non disponible	non disponible	non disponible	non disponible	non disponible

[2] Comprend les soins prolongés et les soins de réadaptation.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement (#)					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total d'établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#)					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement ($)					
a. établissements de chirurgie privés	sans objet	sans objet	sans objet	sans objet	sans objet
b. établissements d'imagerie diagnostique privés	sans objet	sans objet	sans objet	sans objet	sans objet
c. total des paiements aux établissements privés de soins de santé à but lucratif	sans objet	sans objet	sans objet	sans objet	sans objet

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). (#)	3 174	3 419	3 307	2 571	3 037
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). (#)	24 779	28 422	28 007	21 570	29 217
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). ($)	12 506 685	14 156 175	11 292 528	8 655 520	12 152 757
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). ($)	2 321 046	2 947 701	3 451 891	2 694 973	4 089 018

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	3 940,4	4 140,4	3 414,7	3 366,6	4 001,6
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	93,7	103,7	123,3	124,9	139,9

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	530	614	588	565	567
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	5 810	6 331	5 782	6 053	6 335
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	854 120	991 294	1 058 815	1 028 127	1 065 302
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	611 162	658 890	690 877	905 479	2 435 560
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	1 611,6	1 614,5	1 800,7	1 819,7	1 878,8
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	105,2	104,1	119,5	149,6	384,5

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé. (#)	65	94	102	105	101
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants. (#)	2 681	2 953	2 925	3 318	3 256
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés. ($)	496 505	539 940	589 378	590 125	660 870
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés. ($)	185,2	182,8	201,5	177,9	203,0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	970	935	900	915	948
b. spécialistes	972	931	938	939	non disponible
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	1 882	1 866	1 838	1 854	non disponible
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	sans objet	sans objet	sans objet	sans objet	sans objet
b. spécialistes	sans objet	sans objet	sans objet	sans objet	sans objet
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	sans objet	sans objet	sans objet	sans objet	sans objet
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	sans objet	sans objet	sans objet	sans objet	sans objet
b. spécialistes	sans objet	sans objet	sans objet	sans objet	sans objet
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	sans objet	sans objet	sans objet	sans objet	sans objet

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) : (#)					
a. omnipraticiens	5 726 851	5 741 645	5 859 568	5 931 022	6 211 011
b. spécialistes	6 712 187	7 281 386	7 698 155	8 147 749	8 741 628
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	12 439 038	13 023 031	13 557 723	14 078 771	14 952 639
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	non disponible	non disponible	non disponible	non disponible	non disponible
b. services de chirurgie	non disponible	non disponible	non disponible	non disponible	non disponible
c. services de diagnostic	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
e. total	non disponible	non disponible	non disponible	non disponible	non disponible
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : ($)					
a. omnipraticiens	99 387 716	99 489 900	103 068 422	114 868 502	132 200 004
b. spécialistes	146 956 655	153 336 002	165 946 999	178 359 474	199 231 274
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	246 344 371	252 825 902	269 015 421	293 227 976	331 431 278
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	non disponible	non disponible	non disponible	non disponible	non disponible
b. services de chirurgie	non disponible	non disponible	non disponible	non disponible	non disponible
c. services de diagnostic	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
e. total	307 890 771	351 821 602	376 500 221	416 902 176	467 886 678
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	17,4	17,3	17,6	19,4	21,3
b. spécialistes	21,9	21,1	21,6	21,9	22,8
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. paiement moyen pour tous les médecins	19,8	19,4	19,8	20,8	22,2

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services ($)					
a. services médicaux	non disponible	non disponible	non disponible	non disponible	non disponible
b. services de chirurgie	non disponible	non disponible	non disponible	non disponible	non disponible
c. services de diagnostic	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
e. paiement moyen pour tous les services	non disponible	non disponible	non disponible	non disponible	non disponible

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	222 601	217 733	206 521	183 497	192 272
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	6 627 296	6 245 462	6 121 559	5 568 205	6 148 444
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	28,2	28,7	29,6	30,3	32,0

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	6 993	7 222	6 587	7 116	6 763
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	466 323	518 102	519 928	520 712	500 757
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger. ($)	66,7	71,7	78,9	73,2	74,0

Saskatchewan

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	1 027 551	1 020 351	1 031 933	1 041 256	1 021 762

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		75	73	71	71	68
b. soins de longue durée		0	0	0	0	0
c. soins de réadaptation		1	1	1	1	1
d. services diagnostiques aux malades externes		0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)		0	0	0	0	0
f. autres		0	0	0	0	0
g. nombre total d'établissements		76	74	72	72	69
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		3 282 [1]	3 117	3 078	2 944	2 802
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		non disponible	142	142	142	142
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres [2]		non disponible	722	735	718	670
f. nombre total de lits dotés en personnel		non disponible	3 981	3 955	3 804	3 614
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits approuvés		sans objet	sans objet	sans objet	sans objet	sans objet

[1] Des prévisions ont été établies en 1996-1997 pour les lits dotés soins actifs.
[2] "Autre" les lits dotés comprennent les lits de soins prolongés et les lits de soins psychiatriques dans les hôpitaux

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	148 740	146 537	143 604	133 768	131 305 [3]
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	1 401	1 338	1 058	927	977 [3]
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes) [4]	45 224	50 090	53 890	55 426	55 527 [3]
f. en attente d'un autre type de soins	non disponible	non disponible	non disponible	non disponible	non disponible
g. nouveau-nés	13 418	12 882	12 819	12 597	11 993 [3]
h. autres [5]	4 106	3 988	3 309	4 065	4 393 [3]
i. nombre total de radiations [6]	212 889	214 835	214 680	206 783	204 195 [3]
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a soins actifs	5,7	5,7	5,8	5,6	5,7 [3]
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	32,4	30,9	30,5	34,7	31,9 [3]
d. nouveau-nés	3,7	3,7	3,5	3,7	3,6 [3]
e. autres [5]	16,3	16,5	15,4	15,8	15,9 [3]
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs	522 036 613	584 582 800	565 682 800	619 538 151	680 326 248
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	34 822 774	35 115 992	35 437 299	36 824 546	38 249 010
d. services diagnostiques aux	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	556 859 387	619 698 792	601 120 099	656 362 697	718 575 258

[3] Des prévisions ont été établies là où les données sont incomplètes en 2000-2001 pour la durée moyenne de radiation.

[4] Les cas de chirurgie d'un jour (malade externe), sont des cas qui comprennent les procédures à suivre sur la liste publiée en 1991 par l'Institut canadienne sur l'information de la santé.

[5] "Autre" Les radiations sont des radiations des hôpitaux psychiatriques des unités de soins actifs.

[6] Nombre total de radiations exclut les radiations de soins de longue durée.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	0	0	0	0	0
b. établissements d'imagerie diagnostique privés	0	0	0	0	0
c. nombre total d'établissements privés de soins de santé à but lucratif	0	0	0	0	0

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#) :					
a. établissements de chirurgie privés	0	0	0	0	0
b. établissements d'imagerie diagnostique privés	0	0	0	0	0
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	0	0	0	0	0
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement ($) :					
a. établissements de chirurgie privés	0	0	0	0	0
b. établissements d'imagerie diagnostique privés	0	0	0	0	0
c. total des paiements aux établissements privés de soins de santé à but lucratif	0	0	0	0	0

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). (#)	4 788	4 868	4 688	5 019	4 587
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). (#)	35 493	38 279	41 375	44 327	45 195
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). ($)	21 051 931	23 988 792	18 973 762	19 911 192	20 203 300
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). ($)	3 836 058	4 161 896	3 472 464	3 504 388	6 046 600

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	4 396,8	4 927,9	4 047,3	3 967,2	4 404,5
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	108,1	108,7	83,9	79,1	133,8

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	337	317	273	382	286
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	1 574	1 695	1 252	1 201	1 355
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	288 000	710 626	1 193 449	2 484 961	1 022 000
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	132 500	228 968	151 558	348 379	377 600
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	854,6	2 241,7	4 371,6	6 505,1	3 573,4
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	84,2	135,1	121,1	290,1	278,7

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé. (#)	126	119	113	97	92
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants. (#)	18 600	18 700	18 500	18 100	19 900
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés. ($)	1 291 000	1 287 000	1 272 000	1 309 000	1 404 700
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés. ($)	69,4	68,8	68,8	72,3	70,6

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	860	865	907	940	1 016
b. spécialistes	583	592	595	610	593
c. autres	0	0	0	0	0
d. total	1 443	1 457	1 502	1 550	1 609
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	0	0	0	0	0
b. spécialistes	0	0	0	0	0
c. autres	0	0	0	0	0
d. total	0	0	0	0	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	0	0	0	0	0
b. spécialistes	0	0	0	0	0
c. autres	0	0	0	0	0
d. total	0	0	0	0	0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (#) (rémunération à l'acte) :					
a. omnipraticiens	6 868 246	6 595 192	6 742 712	6 785 673	6 873 539
b. spécialistes	3 121 981	3 068 576	3 127 345	3 163 046	3 250 953
c. autres	0	0	0	0	0
d. total	9 990 227	9 663 768	9 870 057	9 948 719	10 124 492
34. Nombre de services médicaux assurés, par catégorie de services (#) :					
a. services médicaux	6 229 799 [8]	5 989 580 [8]	6 048 849 [8]	6 028 070 [8]	6 071 567 [8]
b. services de chirurgie	739 787 [9]	728 803 [9]	735 770 [9]	723 626 [9]	787 655 [9]
c. services de diagnostic	2 404 982 [10]	2 323 818 [10]	2 345 180 [10]	2 312 606 [10]	2 288 038 [10]
d. autres	615 659 [11]	621 567 [11]	740 258 [11]	884 417 [11]	977 232 [11]
e. total	9 990 227	9 663 768	9 870 057	9 948 719	10 124 492
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins ($) :					
a. omnipraticiens	122 511 451	119 002 444	128 784 792	133 042 948	134 989 267
b. spécialistes	118 134 845	117 666 741	122 465 930	125 735 201	129 470 569
c. autres	0	0	0	0	0
d. total	240 646 296	236 669 185	251 250 722	258 778 149	264 459 836
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services [7] ($) :					
a. services médicaux	140 292 403 [8]	137 691 861 [8]	143 548 623 [8]	148 848 496 [8]	151 152 270 [8]
b. services de chirurgie	52 990 753 [9]	51 536 110 [9]	51 255 592 [9]	50 843 890 [9]	51 681 286 [9]
c. services de diagnostic	38 430 693 [10]	37 944 132 [10]	40 473 208 [10]	41 503 336 [10]	43 216 810 [10]
d. autres	8 932 447 [11]	9 497 081 [11]	15 973 299 [11]	17 582 427 [11]	18 409 471 [11]
e. total	240 646 296	236 669 184	251 250 722	258 778 149	264 459 837
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins ($) :					
a. omnipraticiens	17,8	18,0	19,1	19,6	19,6
b. spécialistes	37,8	38,3	39,2	39,8	39,8
c. autres	0,0	0,0	0,0	0,0	0,0
d. paiement moyen pour tous les médecins	24,1	24,5	25,5	26,0	26,1

[7] Rémunération à l'acte.

[8] Comprend les visites, les soins dans les hôpitaux, psychothérapie.

[9] Comprend les chirurgies, assistant à la chirurgie, obstétrique, anesthésie.

[10] Comprend les rayons x, laboratoire, diagnostic.

[11] Comprend les suppléments et les primes sur appel.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services ($)					
a. services médicaux	22,5 [8]	23,0 [8]	23,7 [8]	24,7 [8]	24,9 [8]
b. services de chirurgie	71,6 [9]	70,7 [9]	69,7 [9]	70,3 [9]	65,6 [9]
c. services de diagnostic	16,0 [10]	16,3 [10]	17,3 [10]	17,9 [10]	18,9 [10]
d. autres	14,5 [11]	15,3 [11]	21,6 [11]	19,9 [11]	18,8 [11]
e. paiement moyen pour tous les services	24,1	24,5	25,5	26,0	26,1

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	318 200	361 000	374 900	392 400	425 800
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	9 286 800	10 501 400	10 897 500	12 237 200	13 767 600
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	29,2	29,1	29,1	31,2	32,3

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	non disponible	non disponible	non disponible	non disponible	non disponible
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	519 400	644 300	658 400	1 186 900	722 400
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger. ($)	non disponible	non disponible	non disponible	non disponible	non disponible

[8] Comprend les visites, les soins dans les hôpitaux, psychothérapie

[9] Comprend les chirurgies, assistant à la chirurgie, obstétrique, anesthésie

[10] Comprend les rayons x, laboratoire, diagnostic

[11] Comprend les suppléments et les primes sur appel

Alberta

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	2 786 526	2 847 538	2 912 925	2 957 045	3 007 582

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		102 [2]	102 [2]	102 [2]	102 [2]	102 [2]
b. soins de longue durée		104	104	104	104	105
c. soins de réadaptation		1	1	1	1	1
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)		sans objet	sans objet	sans objet	sans objet	sans objet
f. autres		0	0	0	3	3
g. nombre total d'établissements		207	207	207	210	211
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		6 176	6 305	6 404	6 275	6 284
b. soins de longue durée		6 179	6 179	6 179	6 179	6 358
c. soins de réadaptation		240	240	240	240	240
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits dotés en personnel		12 595	12 724	12 823	12 694	12 882
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		9 788	9 788	9 788	9 788	9 788
b. soins de longue durée		6 114	6 114	6 114	6 114	6 164
c. soins de réadaptation		240	240	240	240	240
d. services diagnostiques aux malades externes		sans objet	sans objet	sans objet	sans objet	sans objet
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits approuvés		16 142	16 142	16 142	16 142	16 192

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

[2] Section 2 - les données sur les établissements de soins actifs ont été modifiées pour les exercices 1996-1997 à 1999-2000 afin d'inclure un établissement supplémentaire.

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins :	(#)					
a. soins actifs		non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée		non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation		non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes		non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)		non disponible	non disponible	non disponible	non disponible	non disponible
f. en attente d'un autre type de soins		non disponible	non disponible	non disponible	non disponible	non disponible
g. nouveau-nés		non disponible	non disponible	non disponible	non disponible	non disponible
h. autres		non disponible	non disponible	non disponible	non disponible	non disponible
i. nombre total de radiations		332 665	334 869	346 092	346 316	non disponible
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins :	(# de jours)					
a. soins actifs		non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée		non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation		non disponible	non disponible	non disponible	non disponible	non disponible
d. nouveau-nés		non disponible	non disponible	non disponible	non disponible	non disponible
e. autres		non disponible	non disponible	non disponible	non disponible	non disponible
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement :	($)					
a. soins actifs		sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée		sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation		sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux		sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour		sans objet	sans objet	sans objet	sans objet	sans objet
f. autres		sans objet	sans objet	sans objet	sans objet	sans objet
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés		sans objet	sans objet	sans objet	sans objet	sans objet

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)	sans objet	sans objet	sans objet	sans objet	sans objet
f. autres	sans objet	sans objet	sans objet	sans objet	sans objet
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	sans objet	sans objet	sans objet	sans objet	sans objet
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total d'établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement :	(#)					
a. établissements de chirurgie privés		non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés		non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif		non disponible	non disponible	non disponible	non disponible	non disponible
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement :	($)					
a. établissements de chirurgie privés		non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés		non disponible	non disponible	non disponible	non disponible	non disponible
c. total des paiements aux établissements privés de soins de santé à but lucratif		non disponible	non disponible	non disponible	non disponible	non disponible

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	(#)	4 565	4 656	4 714	4 820	4 535
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	(#)	55 477	56 408	57 574	59 443	59 815
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	16 065 099	14 699 049	13 269 781	13 632 730	12 647 870
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	5 170 997	5 287 271	6 706 065	6 920 702	6 955 005

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	3 519,2	3 157,0	2 815,0	2 828,4	2 788,9
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	93,2	93,7	116,5	116,4	116,3

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger. [3]	(#)	4 686 [4]	3 843 [4]	4 005 [4]	5 215 [4]	4 151
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger. [3]	(#)	4 696 [4]	4 668 [4]	3 777 [4]	5 097 [4]	3 945
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	437 393 [4]	363 087 [4]	356 747 [4]	483 648 [4]	374 005
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	351 698 [4]	349 217 [4]	275 687 [4]	364 087 [4]	298 725
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	93,3 [4]	94,5 [4]	89,1 [4]	92,7 [4]	90,1
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	74,9 [4]	74,8 [4]	73,0 [4]	71,4 [4]	75,7

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

[3] Les données représentent le nombre total d'unités de service payées pour des services hospitaliers.

[4] Les sections 20 à 25 ont été modifiées des éditions précédentes du Rapport annuel sur la Loi canadienne sur la santé en raison d'une erreur au niveau de l'identification de la catégorie de services (patients internes et patients externes) et des paiements liés à ces services pour les années fiscaux de1996-1997 à 1999-2000.

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
26. Nombre de dentistes qui participent au régime d'assurance-santé.	(#)	241	230	232	250	232
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants.	(#)	9 063	10 648	11 920	14 292	14 708
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés.	($)	1 571 065	1 691 797	1 853 322	2 092 003	2 116 386
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés.	($)	173,3	158,9	155,5	146,4	143,9

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		2 395	2 365	2 464	2 545	2 659
b. spécialistes		1 833	1 903	1 978	2 096	2 197
c. autres		sans objet	sans objet	sans objet	sans objet	sans objet
d. total		4 228	4 268	4 442	4 641	4 856
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		sans objet	sans objet	sans objet	sans objet	sans objet
b. spécialistes		sans objet	sans objet	sans objet	sans objet	sans objet
c. autres		sans objet	sans objet	sans objet	sans objet	sans objet
d. total		sans objet	sans objet	sans objet	sans objet	sans objet
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		0	0	0	0	0
b. spécialistes		0	0	0	0	1
c. autres		0	0	0	0	0
d. total		0	0	0	0	1

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) (#)					
a. omnipraticiens	13 947 484	14 377 354	14 974 783	15 543 092	15 914 666
b. spécialistes	9 291 690	9 844 887	10 392 632	10 798 883	11 319 078
c. autres	0	0	0	0	0
d. total	23 239 174	24 222 241	25 367 415	26 341 975	27 233 744
34. Nombre de services médicaux assurés, par catégorie de services (#)					
a. services médicaux	17 875 863 [5]	18 411 601 [5]	19 119 550 [5]	19 829 029 [5]	20 328 498 [5]
b. services de chirurgie	1 117 537 [5]	1 155 663 [5]	1 211 712 [5]	1 238 043 [5]	1 316 312 [5]
c. services de diagnostic	4 245 774 [5]	4 654 977 [5]	5 036 153 [5]	5 274 903 [5]	5 588 934 [5]
d. autres	0	0	0	0	0
e. total	23 239 174 [5]	24 222 241 [5]	25 367 415 [5]	26 341 975 [5]	27 233 744 [5]
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins ($)					
a. omnipraticiens	346 643 288	357 611 870	383 842 634	410 502 506	430 681 658
b. spécialistes	399 772 398	427 232 284	464 270 463	493 040 446	528 392 197
c. autres	0	0	0	0	0
d. total	746 415 686	784 844 154	848 113 097	903 542 952	959 073 855
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services ($)					
a. services médicaux	498 946 649 [5]	514 667 078 [5]	549 507 274 [5]	586 587 852 [5]	618 596 110 [5]
b. services de chirurgie	120 802 134 [5]	125 595 149 [5]	133 916 239 [5]	140 067 988 [5]	150 223 933 [5]
c. services de diagnostic	126 666 903 [5]	144 581 927 [5]	164 689 584 [5]	176 887 112 [5]	190 253 812 [5]
d. autres	0	0	0	0	0
e. total	746 415 686 [5]	784 844 154 [5]	848 113 097 [5]	903 542 952 [5]	959 073 855 [5]
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins ($)					
a. omnipraticiens	24,9	24,9	25,6	26,4	27,1
b. spécialistes	43,0	43,4	44,7	45,7	46,7
c. autres	0,0	0,0	0,0	0,0	0,0
d. paiement moyen pour tous les médecins	32,1	32,4	33,4	34,3	35,2

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

[5] Les sections 34, 36 et 38 ont été modifiées afin de refléter les services et les paiements en fonction du type de service plutôt que de la spécialité du médecin. Ces données ont été modifiées pour les exercices 1996-1997 à 1999-2000 qui se sont terminés le 31 mars.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services ($)					
a. services médicaux	27,9 [5]	28,0 [5]	28,7 [5]	29,6 [5]	30,4 [5]
b. services de chirurgie	108,1 [5]	108,7 [5]	110,5 [5]	113,1 [5]	114,1 [5]
c. services de diagnostic	29,8 [5]	31,1 [5]	32,7 [5]	33,5 [5]	34,0 [5]
d. autres	0,0	0,0	0,0	0,0	0,0
e. paiement moyen pour tous les services	32,1 [5]	32,4 [5]	33,4 [5]	34,3 [5]	35,2 [5]

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	355 985	348 480	359 653	380 635	418 587
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	10 412 565	10 092 203	9 983 110	11 397 620	12 436 188
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	29,3	29,0	27,8	29,9	29,7

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	34 221	30 649	25 192	21 989	20 891
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	1 128 302	972 645	862 852	871 292	907 010
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger. ($)	33,0	31,7	34,3	39,6	43,4

[1] Ces chiffres seront considérés préliminaires jusqu'à la parution du *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* du ministère de la Santé et du Mieux-être de l'Alberta.

[5] Les sections 34, 36 et 38 ont été modifiées afin de refléter les services et les paiements en fonction du type de service plutôt que de la spécialité du médecin. Ces données ont été modifiées pour les exercices 1996-1997 à 1999-2000 qui se sont terminés le 31 mars.

Colombie-Britannique

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)	3 920 273	3 951 853	3 924 490	3 943 991	4 022 789

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs		93	93	94	94	94
b. soins de longue durée		17	17	17	17	18
c. soins de réadaptation		2	3	3	3	3
d. services diagnostiques aux malades externes		25	25	25	25	25
e. services de chirurgie d'un jour (aux malades externes)		sans objet	sans objet	sans objet	sans objet	sans objet
f. autres		1	1	0	0	0
g. nombre total d'établissements		138	139	139	139	140
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée		non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation		non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes		non disponible	non disponible	non disponible	non disponible	non disponible
e. autres		non disponible	non disponible	non disponible	non disponible	non disponible
f. nombre total de lits dotés en personnel		non disponible	non disponible	non disponible	non disponible	non disponible
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs		8 871	8 822	8 834	8 533	8 994
b. soins de longue durée		8 641	8 628	8 018	8 733	9 102
c. soins de réadaptation		193	242	242	468	474
d. services diagnostiques aux malades externes		non disponible	non disponible	non disponible	non disponible	non disponible
e. autres		sans objet	sans objet	sans objet	sans objet	sans objet
f. nombre total de lits approuvés		17 705	17 692	17 094	17 734	18 570

Des estimations et des projections ont été faites lorsque les données étaient incomplètes.

Il y a une certaine inconstance dans les rapports en raison de la régionalisation et des changements apportés aux rapports à remettre aux autorités sanitaires.

Les chiffres peuvent différer de la Base de données sur les congés des patients de l'Institut canadien d'information sur la santé parce que les définitions varient.

Certaines autorités sanitaires utilisent une catégorie générale (c.-à-d., autre) pour les statistiques. La plupart du temps, ces données sont incluses dans la catégorie des soins actifs.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	345 523	367 465	376 369	374 246	378 427
b. soins de longue durée	7 805	9 072	9 016	7 132	7 502
c. soins de réadaptation	2 612	2 445	2 497	2 466	2 753
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	295 117	289 951	274 295	293 530	288 705
f. en attente d'un autre type de soins	5 365	3 591	3 060	3 798	3 882
g. nouveau-nés	36 462	40 968	41 085	40 566	39 947
h. autres	sans objet	sans objet	sans objet	sans objet	sans objet
i. nombre total de radiations	692 884	713 492	706 322	721 738	721 216
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs	5,6	5,9	5,8	6,0	6,0
b. soins de longue durée	351,0	325,7	211,5	340,6	379,0
c. soins de réadaptation	33,5	32,2	28,9	28,5	26,9
d. nouveau-nés	2,9	6,7	2,2	2,4	2,6
e. autres	30,8	33,7	29,0	29,3	28,5
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	non disponible	non disponible	non disponible	non disponible	non disponible

Des estimations et des projections ont été faites lorsque les données étaient incomplètes.

Il y a une certaine inconstance dans les rapports en raison de la régionalisation et des changements apportés aux rapports à remettre aux autorités sanitaires.

Les chiffres peuvent différer de la Base de données sur les congés des patients de l'Institut canadien d'information sur la santé parce que les définitions varient.

Certaines autorités sanitaires utilisent une catégone générale (c.-à-d., autre) pour les statistiques. La plupart du temps, ces données sont incluses dans la catégorie des soins actifs.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. services diagnostiques aux malades externes	non disponible	non disponible	non disponible	non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)	non disponible	non disponible	non disponible	non disponible	non disponible
f. autres	non disponible	non disponible	non disponible	non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	non disponible	non disponible	non disponible	non disponible	non disponible
b. soins de longue durée	non disponible	non disponible	non disponible	non disponible	non disponible
c. soins de réadaptation	non disponible	non disponible	non disponible	non disponible	non disponible
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	1	1
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total d'établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	1	1

Des estimations et des projections ont été faites lorsque les données étaient incomplètes.

Il y a une certaine inconstance dans les rapports en raison de la régionalisation et des changements apportés aux rapports à remettre aux autorités sanitaires.

Les résultats seront différents si les données de la Base de données sur les congés des patients sont utilisées pour faire la comparaison, et ce parce que les définitions varient.

Certaines autorités sanitaires utilisent une catégorie générale (c.-à-d., autre) pour les statistiques. La plupart du temps, ces données sont incluses dans la catégorie des soins actifs.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement (#) :					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement ($) :					
a. établissements de chirurgie privés	non disponible	non disponible	non disponible	non disponible	non disponible
b. établissements d'imagerie diagnostique privés	non disponible	non disponible	non disponible	non disponible	non disponible
c. total des paiements aux établissements privés de soins de santé à but lucratif	non disponible	non disponible	non disponible	non disponible	non disponible

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) (#)	7 225	7 383	7 994	7 231	8 113
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) (#)	62 604	68 146	73 807	70 070	83 765
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada) ($)	37 483 341	35 898 630	35 830 522	34 477 406	35 882 521
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada) ($)	6 145 727	7 441 321	9 075 191	9 585 916	9 149 496

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada)	($)	5 188,0	4 862,0	4 482,0	4 768,0	4 422,8
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada)	($)	98,0	109,0	123,0	137,0	109,2

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	2 946	2 888	2 793	2 494	non disponible
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	340	431	435	324	non disponible
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	2 251 755	3 073 456	3 492 437	5 375 289	non disponible
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger	($)	77 502	109 347	100 863	65 137	non disponible
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	764,0	1 064,0	1 250,0	2 155,0	non disponible
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger	($)	228,0	254,0	232,0	201,0	non disponible

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé.	(#)	284	289	280	265	283
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants.	(#)	53 130	53 163	51 096	54 507	55 820
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés.	($)	5 663 597	5 818 127	5 474 563	5 854 368	5 718 859
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés.	($)	106,6	109,4	107,1	107,4	102,0

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		4 154	4 248	4 269	4 276	4 360
b. spécialistes		3 116	3 181	3 232	3 269	3 298
c. autres		0	0	0	0	0
d. total		7 270	7 429	7 501	7 545	7 658
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		5	3	4	4	3
b. spécialistes		13	11	13	10	5
c. autres		0	0	0	0	0
d. total		18	14	17	14	8
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		1	1	1	1	1
b. spécialistes		0	0	0	0	0
c. autres		0	0	0	0	0
d. total		1	1	1	1	1

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) : (#)					
a. omnipraticiens	22 197 196	22 378 959	21 903 525	22 875 620	23 051 810
b. spécialistes	28 828 096	29 424 394	29 860 276	32 697 836	34 551 897
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	51 025 292	51 803 353	51 763 801	55 573 456	57 603 707
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	23 535 944 [1]	24 309 601 [1]	24 012 366 [1]	25 065 926 [1]	25 201 483 [1]
b. services de chirurgie	5 601 151 [2]	4 209 195 [2]	4 163 434 [2]	4 426 656 [2]	4 417 069 [2]
c. services de diagnostic	21 888 197 [3]	23 294 557 [3]	23 588 001 [3]	26 080 874 [3]	27 985 155 [3]
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
e. total	51 025 292	51 813 353	51 763 801	55 573 456	57 603 707
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : [4] ($)					
a. omnipraticiens	613 317 385	614 713 789	626 992 277	654 305 224	663 325 757
b. spécialistes	817 739 525	831 174 498	845 235 143	928 642 083	965 611 051
c. autres	sans objet	sans objet	sans objet	sans objet	sans objet
d. total	1 431 056 910	1 445 888 287	1 472 227 420	1 582 947 307	1 628 936 808
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : [5] ($)					
a. services médicaux	834 731 808	850 453 217	874 004 742	920 552 743	936 095 517
b. services de chirurgie	230 651 787	231 507 497	229 196 329	250 267 000	252 827 989
c. services de diagnostic	365 673 314	363 927 573	369 026 348	412 127 564	440 013 302
d. autres	sans objet	sans objet	sans objet	sans objet	sans objet
e. total	1 431 056 909	1 445 888 287	1 472 227 419	1 582 947 307	1 628 936 808
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	27,6	27,4	28,6	28,6	27,8
b. spécialistes	28,3	28,2	28,3	28,4	28,0
c. autres	0,0	0,0	0,0	0,0	0,0
d. paiement moyen pour tous les médecins	28,0	27,9	28,4	28,5	28,3

1 Les services médicaux comprennent : les examens régionaux, les consultations, les examens complets, les services de consultation, les visites à domicile, les visites d'urgence, les visites d'établissements, les dialyses/transfusions, les services généraux et la radiothérapie (codes de service 1 à 8; 22 à 28; 30; et 46 à 48).

2 Les services chirurgicaux comprennent : anesthésie, chirurgie cardiovasculaire, obstétrique, chirurgies mineure et majeure (codes de service 40 à 45).

3 Les services de diagnostic comprennent : ophtalmologie de diagnostic, radiologie de diagnostic, ultrasons de diagnostic, médecine nucléaire, pathologie, exploration pulmonaire fonctionnelle, électrodiagnostic et procédures en cardiologie (codes de service 89 à 98).

4 La dépense comprend le montant versé, la Northern and Isolation Allowance (programme d'indemnité de poste en région isolée et septentrionale) et les primes et exclut les frais de fournitures médicales.

5 Les services payés représentent les services du MSP (régime de soins médicaux) payés à l'acte qui ont été offerts entre le 1er avril 2000 et le 31 mars 2001 et qui ont été payés au 30 septembre 2001.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	35,5	35,0	36,4	36,7	37,1
b. services de chirurgie	41,2	55,0	55,0	56,5	57,2
c. services de diagnostic	16,7	15,6	15,6	15,8	15,7
d. autres	0,0	0,0	0,0	0,0	0,0
e. paiement moyen pour tous les services	28,0	27,9	28,4	28,5	28,3

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	477 236	461 571	438 186	446 232	non disponible
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	13 844 944	13 849 906	13 495 893	14 134 689	non disponible
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	29,0	30,0	30,8	31,7	non disponible

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	non disponible	non disponible	73 297	66 361	68 707
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	non disponible	non disponible	3 504 870	3 336 415	3 947 293
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger ($)	non disponible	non disponible	47,8	50,3	57,5

Yukon

Personnes inscrites					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars. (#)	33 984	33 557	31 925	31 255	31 133

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement : (#)					
a. soins actifs	2	2	2	2	2
b. soins de longue durée	0	0	0	0	0
c. soins de réadaptation	0	0	0	0	0
d. services diagnostiques aux malades externes	0	0	0	0	0
e. services de chirurgie d'un jour (aux malades externes)	0	0	0	0	0
f. autres	13 [1]	13 [1]	13 [1]	13 [1]	13 [1]
g. nombre total d'établissements	15	15	15	15	15
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits : (#)					
a. soins actifs	70	59	59	61	61
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. autres	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. nombre total de lits dotés en personnel	79	76	76	78	78
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits : (#)					
a. soins actifs	70	67	67	69	69
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. autres	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. nombre total de lits approuvés	79	76	76	78	78

[1] Comprend des centres de santé et un poste sanitaire.

[2] Lits pour chirurgie d'un jour.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs	3 481	3 283	3 117	2 967	3 021
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)	1 646	1 524	1 606	1 624	1 619
f. en attente d'un autre type de soins	0	0	0	0	0
g. nouveau-nés	452	437	392	374	363
h. autres	0 [1]	0 [1]	0 [1]	0 [1]	0 [1]
i. nombre total de radiations	5 579	5 244	5 115	4 965	5 003
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs	4,5	4,0	4,5	4,7	4,7
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. nouveau-nés	3,0	3,0	2,9	3,0	3,1
e. autres	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs	18 567 847	18 836 846	19 023 617	19 587 158	20 350 026
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour	0	0	0	0	0
f. autres	4 692 893 [1]	4 722 168 [1]	4 796 107 [1]	5 502 144 [1]	5 483 948 [1]
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés	23 260 740	23 559 014	23 819 724	25 089 302	25 833 974

[1] Comprend des centres de santé et un poste sanitaire.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs	505,0	505,0	694,5	694,5	694,5
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	non disponible	non disponible	non disponible	non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs	89,0	89,0	110,0	110,0	110,0
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. services diagnostiques aux malades externes	sans objet	sans objet	sans objet	sans objet	sans objet
e. services de chirurgie d'un jour (aux malades externes)	292,0	292,0	400,0	400,0	400,0
f. autres	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs	311,1	362,7	349,7	337,2	335,5
b. soins de longue durée	sans objet	sans objet	sans objet	sans objet	sans objet
c. soins de réadaptation	sans objet	sans objet	sans objet	sans objet	sans objet
d. autres	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]	non disponible [1]
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés	0	0	0	0	0
b. établissements d'imagerie diagnostique privés	0	0	0	0	0
c. nombre total d'établissements privés de soins de santé à but lucratif	0	0	0	0	0

[1] Comprend des centres de santé et un poste sanitaire.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement : (#)					
a établissements de chirurgie privés	0	0	0	0	0
b établissements d'imagerie diagnostique privés	0	0	0	0	0
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif	0	0	0	0	0
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : ($)					
a. établissements de chirurgie privés	0	0	0	0	0
b. établissements d'imagerie diagnostique privés	0	0	0	0	0
c. total des paiements aux établissements privés de soins de santé à but lucratif	0	0	0	0	0

Services hospitaliers rendus hors province ou territoire (au Canada) [3]					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). (#)	712	732	769	735	698
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). (#)	5 621	6 109	6 637	7 025	6 690
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). ($)	4 751 127	4 434 174	4 196 661	4 683 562	4 220 525
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). ($)	584 070	645 165	826 425	920 769	857 580

[3] Le Yukon continue de recevoir des réclamations des autres provinces et territoires du Canada. Les provinces et territoires ont jusqu'à douze mois pour soumettre leurs réclamations.

Services hospitaliers rendus hors province ou territoire (au Canada) [3]						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)	6 673,0	6 058,0	5 457,0	6 372,0	6 047,0
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)	104,0	106,0	125,0	131,0	128,0

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)	11	14	13	11	8
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)	67	42	53	67	54
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	62 847	34 445	45 440	22 125	20 597
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	32 462	5 502	7 354	7 080	8 368
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)	5 713,0	2 460,0	3 495,0	2 011,0	2 575,0
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)	485,0	131,0	139,0	102,0	156,0

[3] Le Yukon continue de recevoir des réclamations des autres provinces et territoires du Canada. Les provinces et territoires ont jusqu'à douze mois pour soumettre leurs réclamations.

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé.	(#)	12	10	12	9	11
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants.	(#)	309	203	297	214	222
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés.	($)	75 331	50 840	64 397	59 458	50 876
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés.	($)	243,8	250,4	217,2	277,8	229,2

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		48	52	40	41	43
b. spécialistes		4	4	4	5	6
c. autres		0	0	0	0	0
d. total		52	56	44	46	49
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		0	0	0	0	0
b. spécialistes		0	0	0	0	0
c. autres		0	0	0	0	0
d. total		0	0	0	0	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens		0	0	0	0	0
b. spécialistes		0	0	0	0	0
c. autres		0	0	0	0	0
d. total		0	0	0	0	0

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) : (#)					
a. omnipraticiens	161 680	164 544	151 743	153 542	164 497
b. spécialistes	12 522	10 885	14 170	11 704	14 789
c. autres	0	0	0	0	0
d. total	174 202	175 429	165 913	165 246	179 286
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	125 230	127 479	120 830	123 333	131 685
b. services de chirurgie	26 775	25 425	23 110	22 092	25 670
c. services de diagnostic	22 197	22 525	21 972	19 822	18 978
d. autres	0	0	0	0	0
e. total	174 202	175 429	165 912	165 247	176 333
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : ($)					
a. omnipraticiens	5 198 864	5 335 775	5 058 606	5 248 704	5 803 619
b. spécialistes	1 076 028	1 184 312	1 321 577	1 189 271	1 263 380
c. autres	0	0	0	0	0
d. total	6 274 892	6 520 087	6 380 183	6 437 975	7 066 999
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	5 040 362	5 182 278	5 026 530	5 144 453	5 729 729
b. services de chirurgie	918 797	995 148	1 005 170	978 628	1 028 529
c. services de diagnostic	315 733	342 661	348 483	314 893	308 741
d. autres	0	0	0	0	0
e. total	6 274 892	6 520 087	6 380 183	6 437 974	7 066 999
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	32,2	32,4	33,3	34,2	35,3
b. spécialistes	85,9	108,8	93,3	101,6	85,4
c. autres	0,0	0,0	0,0	0,0	0,0
d. paiement moyen pour tous les médecins	36,0	37,2	38,5	39,0	39,4

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	40,2	40,7	41,6	41,7	43,5
b. services de chirurgie	34,3	39,1	43,5	44,3	40,1
c. services de diagnostic	14,2	15,2	15,9	15,9	16,3
d. autres	0,0	0,0	0,0	0,0	0,0
e. paiement moyen pour tous les services	36,0	37,2	38,5	39,0	40,1

Services médicaux rendus hors province ou territoire (au Canada)					
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada). (#)	33 313	28 656	29 834	31 020	36 828
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	1 180 306	1 183 519	1 207 371	1 404 195	1 642 495
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada). ($)	35,4	41,3	40,5	45,3	44,6

Services médicaux rendus à l'étranger					
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés. (#)	non disponible	non disponible	non disponible	non disponible	non disponible
43. Total des paiements pour des services médicaux assurés fournis à l'étranger. ($)	non disponible	non disponible	non disponible	non disponible	non disponible
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger. ($)	non disponible	non disponible	non disponible	non disponible	non disponible

Services médicaux rendus dans la province ou le territoire [4]					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
45. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens	non disponible	non disponible	non disponible	non disponible	non disponible
b. spécialistes	non disponible	non disponible	non disponible	non disponible	non disponible
c. nombre total de médecins	non disponible	non disponible	non disponible	non disponible	non disponible
46. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) : (#)					
a. omnipraticiens	23 759	27 583	30 391	27 757	21 028
b. spécialistes	11 411	11 848	10 443	11 332	5 254
c. nombre total de médecins	35 170	39 431	40 834	39 089	26 282
47. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	29 629	33 975	33 007	31 609	19 865
b. services de chirurgie	2 134	1 842	4 483	5 141	4 208
c. services de diagnostic	3 407	3 614	3 344	2 339	2 209
d. nombre total de services médicaux assurés	35 170	39 431	40 834	39 089	26 282
48. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : (#)					
a. omnipraticiens	815 233	983 271	994 636	907 848	756 866
b. spécialistes	924 791	756 719	681 869	727 972	695 927
c. total des paiements aux médecins	1 740 024	1 739 990	1 676 505	1 635 820	1 452 793
49. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : (#)					
a. services médicaux	1 415 810	1 542 518	1 477 892	1 436 115	1 159 117
b. services de chirurgie	232 831	112 736	121 755	132 349	208 679
c. services de diagnostic	91 383	84 736	76 857	67 356	84 997
d. total des paiements aux médecins	1 740 024	1 739 990	1 676 504	1 635 820	1 452 793
50. Paiement moyen pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens	34,3	35,7	32,7	32,7	36,0
b. spécialistes	81,0	63,9	65,3	64,2	132,5
c. paiement moyen pour tous les services médicaux assurés	49,5	44,1	41,1	41,9	55,3
51. Paiement moyen pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux	47,8	45,4	44,8	45,4	58,4
b. services de chirurgie	109,1	61,2	27,2	25,7	49,6
c. services de diagnostic	26,8	23,5	23,0	28,8	38,5
d. paiement moyen pour tous les services médicaux assurés	49,5	44,1	41,1	41,9	55,3

[4] Spécialistes itinérants, médecins suppléants et remboursements aux membres

Territoires du Nord-Ouest

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)				41 000	41 673

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs					4 hôpitaux	4 hôpitaux
b. soins de longue durée					non disponible [1]	non disponible [1]
c. soins de réadaptation					non disponible [1]	non disponible [1]
d. services diagnostiques aux malades externes					non disponible [1]	non disponible [1]
e. services de chirurgie d'un jour (aux malades externes)					non disponible [1]	non disponible [1]
f. autres					28	28
g. nombre total d'établissements					32	32
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					non disponible	non disponible
d. services diagnostiques aux malades externes					non disponible	non disponible
e. autres					non disponible	non disponible
f. nombre total de lits dotés en personnel					212	220
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits	(#)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					non disponible	non disponible
d. services diagnostiques aux malades externes					non disponible	non disponible
e. autres					non disponible	non disponible
f. nombre total de lits approuvés					212	220

[1] Aucun établissement des Territoires du Nord-Ouest n'offre principalement ce type de soins. En effet, ce sont les 4 établissements de soins actifs qui offrent les soins de longue durée, les soins prolongés, les services de chirurgie d'un jour, les services aux patients externes, les services de diagnostic et les services de réadaptation.

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (#)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				7 907	7 185
d. services diagnostiques aux malades externes				non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)				2 748	2 438
f. en attente d'un autre type de soins				non disponible	non disponible
g. nouveau-nés				472	717
h. autres				59 253	64 995
i. nombre total de radiations				70 380	75 335
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins (# de jours)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				15,2	10,6
d. nouveau-nés				2,9	3,0
e. autres				4,8	4,3
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement ($)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				1 205 469	1 129 741
d. services diagnostiques aux				non disponible	non disponible
e. services de chirurgie d'un jour				1 099 200	975 200
f. autres				34 548 885	33 823 823
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés				36 853 554	35 928 763

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins :	($)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					1 479,6	1 625,7
d. autres					1 354,7	1 357,7
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins :	($)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					110,0	109,8
d. services diagnostiques aux malades externes					non dispunible	non disponible
e. services de chirurgie d'un jour (aux malades externes)					400,0	400,0
f. autres					109,1	108,6
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins :	($)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					152,5	157,2
d. autres					570,6	510,6
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement :	(#)					
a. établissements de chirurgie privés					0	0
b. établissements d'imagerie diagnostique privés					0	0
c. nombre total d'établissements privés de soins de santé à but lucratif					0	0

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement :	(#)					
a. établissements de chirurgie privés					0	0
b. établissements d'imagerie diagnostique privés					0	0
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif					0	0
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement :	($)					
a. établissements de chirurgie privés					0	0
b. établissements d'imagerie diagnostique privés					0	0
c. total des paiements aux établissements privés de soins de santé à but lucratif					0	0

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	(#)				1 063	930
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	(#)				7 798	7 999
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)				7 092 119	5 254 269
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)				1 150 303	1 361 059

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)				6 671,8	5 649,8
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)				147,5	170,2

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)				6	5
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)				12	15
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)				10 190	2 908
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)				2 270	1 459
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)				1 698,4	581,5
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)				189,2	97,3

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services de chirurgie dentaire rendus dans la province ou le territoire					
Services dentaires assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé. (#)				non disponible	non disponible
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants. (#)				non disponible	non disponible
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés. ($)				non disponible	non disponible
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés. ($)				non disponible	non disponible

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens				35 [2]	29 [2]
b. spécialistes				18 [2]	18 [2]
c. autres				106 [3]	151 [3]
d. total				159 [4]	198 [4]
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens				0	0
b. spécialistes				0	0
c. autres				0	0
d. total				0	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins : (#)					
a. omnipraticiens				0	0
b. spécialistes				0	0
c. autres				0	0
d. total				0	0

2 Base de données médicales Southam de l'Institut canadien d'information sur la santé.

3 Il s'agit d'une estimation du nombre de suppléants.

4 Ce total est fondé sur le nombre de noms dans notre base de données.

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services médicaux rendus dans la province ou le territoire					
Services médicaux assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) (#) :					
a. omnipraticiens				134 396	81 777
b. spécialistes				9 432	5 355
c. autres				7 203	0
d. total				151 031	87 132
34. Nombre de services médicaux assurés, par catégorie de services : (#)					
a. services médicaux				non disponible	non disponible
b. services de chirurgie				non disponible	non disponible
c. services de diagnostic				non disponible	non disponible
d. autres				non disponible	non disponible
e. total				212 997	199 277
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins : ($)					
a. omnipraticiens				5 225 870	3 380 039
b. spécialistes				645 959	584 280
c. autres				347 425	0
d. total				6 219 254	3 964 319
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services : ($)					
a. services médicaux				non disponible	non disponible
b. services de chirurgie				non disponible	non disponible
c. services de diagnostic				non disponible	non disponible
d. autres				non disponible	non disponible
e. total				9 315 675	8 468 518
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins : ($)					
a. omnipraticiens				38,9	41,3
b. spécialistes				68,5	109,1
c. autres				48,2	non disponible
d. paiement moyen pour tous les médecins				41,2	45,5

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services :	($)					
a. services médicaux					non disponible	non disponible
b. services de chirurgie					non disponible	non disponible
c. services de diagnostic					non disponible	non disponible
d. autres					non disponible	non disponible
e. paiement moyen pour tous les services					43,7	42,5

Services médicaux rendus hors province ou territoire (au Canada)						
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada).	(#)				36 002	35 301
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)				1 931 528	1 908 213
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)				53,7	54,1

Services médicaux rendus à l'étranger						
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés.	(#)				212	176
43. Total des paiements pour des services médicaux assurés fournis à l'étranger.	($)				18 197	13 296
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger.	($)				85,8	75,5

Les statistiques des exercices 1996-1997 à 1998-1999 ne sont pas présentées parce que, à compter du 1er avril 1999, le Nunavut a été formé à partir d'une partie des Territoires du Nord-Ouest.

Nunavut

Personnes inscrites						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Nombre total de personnes inscrites au régime d'assurance-santé au 31 mars.	(#)				non disponible	26 829

Services hospitaliers rendus dans la province ou le territoire						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Nombre d'établissements qui fournissent des services hospitaliers assurés (sauf les hôpitaux psychiatriques et les maisons de repos), par type principal de soins offerts par l'établissement :	(#)					
a. soins actifs					1 hôpital 25 centre de santé	1 hôpital 25 centre de santé
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					non disponible	non disponible
d. services diagnostiques aux malades externes					non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)					non disponible	non disponible
f. autres					non disponible	non disponible
g. nombre total d'établissements					non disponible	non disponible
3. Nombre de lits dotés en personnel dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					non disponible	non disponible
d. services diagnostiques aux malades externes					non disponible	non disponible
e. autres					non disponible	non disponible
f. nombre total de lits dotés en personnel					non disponible	non disponible
4. Nombre total de lits approuvés dans tous les établissements qui fournissent des services hospitaliers assurés, par catégorie de lits :	(#)					
a. soins actifs					non disponible	non disponible
b. soins de longue durée					non disponible	non disponible
c. soins de réadaptation					non disponible	non disponible
d. services diagnostiques aux malades externes					non disponible	non disponible
e. autres					non disponible	non disponible
f. nombre total de lits approuvés					non disponible	non disponible

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Nombre de radiations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (#)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. services diagnostiques aux malades externes				non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)				non disponible	non disponible
f. en attente d'un autre type de soins				non disponible	non disponible
g. nouveau-nés				non disponible	non disponible
h. autres				non disponible	non disponible
i. nombre total de radiations				non disponible	non disponible
6. Durée moyenne des hospitalisations dans tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : (# de jours)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. nouveau-nés				non disponible	non disponible
e. autres				non disponible	non disponible
7. Total des paiements aux établissements qui fournissent des services hospitaliers assurés, par type principal de soins offerts par l'établissement : ($)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. services diagnostiques aux				non disponible	non disponible
e. services de chirurgie d'un jour				non disponible	non disponible
f. autres				non disponible	non disponible
g. total des paiements aux établissements qui fournissent des services hospitaliers assurés				non disponible	non disponible

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
8. Coût quotidien moyen des soins aux malades hospitalisés offerts par tous les établissements qui fournissent des services hospitaliers assurés aux malades hospitalisés, par type de soins : ($)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. autres				non disponible	non disponible
9. Coût moyen par visite pour les services offerts aux malades externes par tous les établissements qui fournissent des services hospitaliers assurés aux malades externes, par type de soins : ($)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. services diagnostiques aux malades externes				non disponible	non disponible
e. services de chirurgie d'un jour (aux malades externes)				non disponible	non disponible
f. autres				non disponible	non disponible
10. Coût moyen par visite pour les services offerts (aux malades hospitalisés et aux malades externes) par tous les établissements qui fournissent des services hospitaliers assurés, par type de soins : ($)					
a. soins actifs				non disponible	non disponible
b. soins de longue durée				non disponible	non disponible
c. soins de réadaptation				non disponible	non disponible
d. autres				non disponible	non disponible
11. Nombre d'établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés				0	0
b. établissements d'imagerie diagnostique privés				0	0
c. nombre total d'établissements privés de soins de santé à but lucratif				0	0

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services hospitaliers rendus dans la province ou le territoire					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
12. Nombre de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif, par principal type de soins offerts par l'établissement : (#)					
a. établissements de chirurgie privés				0	0
b. établissements d'imagerie diagnostique privés				0	0
c. nombre total de services hospitaliers assurés fournis par des établissements privés de soins de santé à but lucratif				0	0
13. Total des paiements aux établissements privés de soins de santé à but lucratif qui fournissent des services hospitaliers assurés, par principal type de soins offerts par l'établissement : ($)					
a. établissements de chirurgie privés				0	0
b. établissements d'imagerie diagnostique privés				0	0
c. total des paiements aux établissements privés de soins de santé à but lucratif				0	0

Services hospitaliers rendus hors province ou territoire (au Canada)					
Services hospitaliers assurés	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). (#)				1 842	1 549
15. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). (#)				9 656	8 682
16. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada). ($)				8 546 013	7 612 791
17. Total des paiements pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada). ($)				1 470 018	1 352 594

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services hospitaliers rendus hors province ou territoire (au Canada)						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
18. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés hors province ou territoire (au Canada).	($)				4 639,0	4 915,0
19. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes hors province ou territoire (au Canada).	($)				152,0	156,0

Services hospitaliers rendus à l'étranger						
Services hospitaliers assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	(#)				14	0
21. Nombre total de réclamations payées pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	(#)				5	1
22. Total des paiements pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)				12 010	0
23. Total des paiements pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)				1 130	110
24. Paiement moyen pour des services hospitaliers assurés fournis à des malades hospitalisés à l'étranger.	($)				857,0	0,0
25. Paiement moyen pour des services hospitaliers assurés fournis à des malades externes à l'étranger.	($)				226,0	110,0

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services de chirurgie dentaire rendus dans la province ou le territoire						
Services dentaires assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Nombre de dentistes qui participent au régime d'assurance-santé.	(#)				27	21
27. Nombre de services de chirurgie dentaire assurés fournis par des dentistes participants.	(#)				0	non disponible
28. Total des paiements aux dentistes pour des services de chirurgie dentaire assurés.	($)				0	non disponible
29. Paiement moyen (par service) pour des services de chirurgie dentaire assurés.	($)				0,0	non disponible

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Nombre de médecins qui participent au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens					85	59
b. spécialistes					79	55
c. autres					0	0
d. total					164	114
31. Nombre de médecins qui ont opté pour le retrait du régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens					non disponible	0
b. spécialistes					non disponible	0
c. autres					non disponible	0
d. total					non disponible	0
32. Nombre de médecins qui ne participent pas au régime d'assurance-santé, par catégorie de médecins :	(#)					
a. omnipraticiens					non disponible	0
b. spécialistes					non disponible	0
c. autres					non disponible	0
d. total					non disponible	0

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Nombre de services médicaux assurés, par catégorie de médecins (rémunération à l'acte) :	(#)					
a. omnipraticiens					non disponible	61 074
b. spécialistes					non disponible	29 485
c. autres					non disponible	0
d. total					non disponible	0
34. Nombre de services médicaux assurés, par catégorie de services :	(#)					
a. services médicaux					non disponible	non disponible
b. services de chirurgie					non disponible	non disponible
c. services de diagnostic					non disponible	non disponible
d. autres					non disponible	non disponible
e. total					non disponible	non disponible
35. Total des paiements (rémunération à l'acte) aux médecins pour des services médicaux assurés, par catégorie de médecins :	($)					
a. omnipraticiens					2 323 234	2 494 221
b. spécialistes					1 146 522	1 229 811
c. autres					non disponible	0
d. total					3 469 756	3 724 032
36. Total des paiements aux médecins pour des services médicaux assurés, par catégorie de services :	($)					
a. services médicaux					non disponible	non disponible
b. services de chirurgie					non disponible	non disponible
c. services de diagnostic					non disponible	non disponible
d. autres					non disponible	non disponible
e. total					non disponible	non disponible
37. Paiement moyen (par service) pour des services médicaux assurés (rémunération à l'acte), par catégorie de médecins :	($)					
a. omnipraticiens					non disponible	40,8
b. spécialistes					non disponible	41,0
c. autres					non disponible	0,0
d. paiement moyen pour tous les médecins					non disponible	40,9

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Services médicaux rendus dans la province ou le territoire						
Services médicaux assurés		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
38. Paiement moyen (par service) pour des services médicaux assurés, par catégorie de services :	($)					
a. services médicaux					non disponible	non disponible
b. services de chirurgie					non disponible	non disponible
c. services de diagnostic					non disponible	non disponible
d. autres					non disponible	non disponible
e. paiement moyen pour tous les services					non disponible	non disponible

Services médicaux rendus hors province ou territoire (au Canada)						
39. Nombre de services médicaux assurés fournis hors province ou territoire qui ont été payés (au Canada).	(#)				non disponible	55 389
40. Total des paiements pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)				non disponible	3 232 940
41. Paiement moyen (par service) pour des services médicaux assurés fournis hors province ou territoire (au Canada).	($)				non disponible	58,0

Services médicaux rendus à l'étranger						
42. Nombre de services médicaux assurés fournis à l'étranger qui ont été payés.	(#)				0	0
43. Total des paiements pour des services médicaux assurés fournis à l'étranger.	($)				0	0
44. Paiement moyen (par service) pour des services médicaux assurés fournis à l'étranger.	($)				0,0	0,0

Spécialistes itinérants, médecins suppléants et remboursements aux membres.

Annexe B – Loi canadienne sur la santé et *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*

La présente annexe offre au lecteur une codification administrative de la *Loi canadienne sur la santé* et du *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*. Une codification administrative est une interprétation de la loi initiale et comprend toute modification apportée depuis l'adoption de la *Loi*.

Le *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs* est le seul règlement prévu par la *Loi*. En vertu de ce règlement, les provinces et les territoires doivent fournir une estimation des montants de la surfacturation et des frais modérateurs avant le début de chaque exercice financier afin que les pénalités appropriées puissent être perçues. Les provinces et les territoires doivent aussi présenter les états financiers indiquant les montants réels demandés afin de permettre le rapprochement avec les déductions réelles. Le règlement est également présenté sous forme de codification administrative.

Cette codification, qui n'a aucune valeur officielle, était à jour en juin 2001.

CANADA

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

Extra-billing and User Charges Information Regulations

SOR/86-259

June, 2001

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

Juin 2001

WARNING NOTE

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CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6

L.R. (1985), ch. C-6

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CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health services

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

throughout Canada by assisting the provinces in meeting the costs thereof;

Now therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *«dentiste»*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *«services complémentaires de santé»*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory health care service;

"extra-billing" *«surfacturation»*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *«régime d'assurance-santé»*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *«professionnel de la santé»*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *«hôpital»*

"hospital" includes any facility or portion thereof that provides hospital care, including

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

«assuré» *"insured person"*

«assuré» Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

«contribution» [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » *"cash contribution"*

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*.

«dentiste» *"dentist"*

«dentiste» Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

«frais modérateurs» *"user charge"*

«frais modérateurs» Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

acute, rehabilitative or chronic care, but does not include

(a) a hospital or institution primarily for the mentally disordered, or

(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *« services hospitaliers»*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(b) nursing service,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the hospital,

(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(f) medical and surgical equipment and supplies,

(g) use of radiotherapy facilities,

(h) use of physiotherapy facilities, and

(i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *« services de santé assurés»*

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" *« assuré»*

"insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,

(b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

«habitant» *"resident"*

«habitant» Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

«hôpital» *"hospital"*

«hôpital» Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

«loi de 1977» [Abrogée, 1995, ch. 17, art. 34]

«médecin» *"medical practitioner"*

«médecin» Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

«ministre» *"Minister"*

«ministre» Le ministre de la Santé.

«professionnel de la santé» *"health care practitioner"*

«professionnel de la santé» Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

«régime d'assurance-santé» *"health care insurance plan"*

«régime d'assurance-santé» Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

«services complémentaires de santé» *"extended health care services"*

«services complémentaires de santé» Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

«services de chirurgie dentaire» *"surgical-dental services"*

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

(c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" *« médecin »*

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" *«ministre»*

"Minister" means the Minister of Health;

"physician services" *« services médicaux »*

"physician services" means any medically required services rendered by medical practitioners;

"resident" *« habitant »*

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" *«services de chirurgie dentaire»*

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" *«frais modérateurs»*

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11.

«services de santé assurés» *"insured health services"*

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

«services hospitaliers» *"hospital services"*

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

«services médicaux» *"physician services"*

«services médicaux» Services médicalement nécessaires fournis par un médecin.

«surfacturation» *"extra-billing"*

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;

(b) comprehensiveness;

(c) universality;

(d) portability; and

(e) accessibility.

1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à

amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Consentement préalable à la prestation des services de santé assurés facultatifs

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11

(3) Pour l'application du paragraphe (2), «services de santé assurés facultatifs» s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11

Définition de «services de santé assurés facultatifs»

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas

Accessibilité

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)*(c)* shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph *(a)*, conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph *(b)* may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c)* si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a)*, soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b)*, sauf par une loi de la province.

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre

may reasonably require for the purposes of this Act; and

(b) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

DEFAULTS

MANQUEMENTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas

a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Modification des décrets

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Avis

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Entrée en vigueur du décret

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Nouvelle application des réductions ou retenues

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le

Application aux exercices ultérieurs

that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

EXTRA-BILLING AND USER CHARGES

SURFACTURATION ET FRAIS MODÉRATEURS

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

REGULATIONS

RÈGLEMENTS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs *(a)* to *(d)* of the definition "extended health care services" in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13*(a)* and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13*(b)*.

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a)* à *d)* de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13*a)* et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13*b)*.

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)*(a)* or *(b)* except with the agreement of each of the provinces.

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)*a)* ou *b)* qu'avec l'accord de chaque province.

Consentement des provinces

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)*(a)* if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)*a)* s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1er avril 1984.

Exception

Consultation with provinces

(4) No regulation may be made under paragraph (1)*(c)* or *(d)* unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

(4) Il ne peut être pris de règlements en vertu des alinéas (1)*c)* ou *d)* que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

Consultation des provinces

REPORT TO PARLIAMENT

RAPPORT AU PARLEMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

Rapport annuel du ministre

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

WARNING NOTE

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AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(*a*) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the *Extra-billing and User Charges Information Regulations*.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; *(Loi)*

"Minister" means the Minister of National Health and Welfare; *(ministre)*

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. *(exercice)*

TYPES OF INFORMATION

3. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13*(a)* of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13*a)* DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

«exercice» La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. *(fiscal year)*

«Loi» La *Loi canadienne sur la santé*. *(Act)*

«ministre» Le ministre de la Santé nationale et du Bien-être social. *(Minister)*

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13*a)* de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(a) in respect of the estimates referred to in paragraphs 3*(a)* and 4*(a)*, before April 1 of the fiscal year to which they relate; and

(b) in respect of the financial statements referred to in paragraphs 3*(b)* and 4*(b)*, before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3*(a)* and 4*(a)* before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a)* et 4*a)*, avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b)* et 4*b)*, avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3*a)* et 4*a)*, avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

Annexe C – Énoncés de politiques liées à la *Loi canadienne sur la santé* : la lettre « Epp » et la Politique fédérale sur les cliniques privées

La présente annexe est composée des textes de la lettre « Epp » et de la lettre « Marleau » (Politique fédérale sur les cliniques privées). Bien que la *Loi canadienne sur la santé* (LCS) énonce les conditions d'octroi et de versement ainsi que les dispositions que les provinces et les territoires doivent respecter pour avoir droit à la totalité des contributions pécuniaires prévues dans le cadre du Transfert canadien en matière de santé et de programmes sociaux, ces deux documents sont reconnus comme énoncés de la position fédérale concernant l'interprétation de ces conditions et dispositions.

En juin 1985, le ministre fédéral de la Santé et du Bien-être social, M. Jake Epp, a confirmé la politique fédérale d'interprétation et d'application de la LCS dans une lettre envoyé à tous ses homologues provinces et territoires. La lettre « Epp » demeure une référence importante pour l'interprétation de la *Loi*.

Le 6 janvier 1995, la ministre fédérale de la Santé, M^me^ Diane Marleau, a écrit à toutes les provinces et à tous les territoires pour leur communiquer l'interprétation fédérale en ce qui concerne l'inclusion des cliniques privées dans la définition d'« hôpital » dans la LCS. La lettre précisait que la définition d'« hôpital » s'étendait à tout établissement qui fournissait des soins actifs, de réadaptation ou de longue durée, y compris les « cliniques ». Elle les informait également qu'après le 15 octobre, elle considérerait les frais d'établissement chargés aux patients par ces établissements et cliniques comme des frais modérateurs. L'imposition de frais modérateurs contrevient à la LCS et entraîne la retenue d'une partie des transferts de fonds versés à chaque province et territoire.

[Voici le texte de la lettre envoyée le 15 juillet 1985 au ministre des Affaires sociales du Québec par l'honorable Jake Epp, ministre de la Santé et du Bien-être social. (Nota : le ministre Epp a envoyé une lettre identique en anglais aux autres ministres provinciaux et territoriaux de la Santé le 18 juin 1985.)]

Le 15 juillet 1985

OTTAWA, K1A 0K9

Monsieur le Ministre,

Maintenant que j'ai terminé ma ronde de consultations bilatérales au cours des derniers mois avec les ministres provinciaux et territoriaux de la Santé, de même que lors de la rencontre de Winnipeg les 16 et 17 mai, j'aimerais confirmer mes intentions relativement à l'interprétation et à la mise en oeuvre de la Loi canadienne sur la santé. J'apprécierais plus particulièrement que vous me fassiez connaître par écrit vos vues au sujet des projets de règlements ci-joints afin que je puisse prendre les mesures nécessaires pour assurer leur promulgation dès que possible. Aussi, je vous écrirai plus longuement concernant les informations dont j'aurai besoin pour préparer le rapport annuel que je dois soumettre au Parlement.

Tel que souligné lors de notre réunion à Winnipeg, j'entends respecter la compétence des provinces pour tout ce qui touche à la santé et à la prestation des services de santé. Je sais, par conviction et par expérience, qu'on peut accomplir davantage dans l'harmonie et la collaboration que dans la discorde et l'affrontement.

En ce qui a trait à la Loi canadienne sur la santé, la conclusion qui s'impose à moi, à la suite de nos entretiens, c'est que nous sommes tous au même titre les dépositaires de la confiance du public et que nous nous sommes tous promis de conserver un système d'assurance-santé universel, complet, accessible et transférable, géré par un organisme public à l'avantage de tous les habitants du Canada, et que nous allons l'améliorer si c'est possible.

Nos échanges ont renforcé la conviction que j'avais déjà, à savoir que vous avez besoin de suffisamment de latitude et de souplesse administrative pour faire fonctionner vos régimes d'assurance-santé. Vous connaissez bien mieux que moi les besoins et les priorités des habitants de vos provinces par rapport aux facteurs géographiques et économiques. Il est essentiel, par ailleurs, que les provinces assument la responsabilité qui leur incombe en premier d'assurer les services de santé.

J'ai eu en même temps le sentiment que les provinces désirent que le gouvernement fédéral continue de jouer un rôle concret, tant sur le plan monétaire qu'autrement, afin de les aider dans leurs efforts pour tenter de réaliser les objectifs fondamentaux du système de soins: protéger, favoriser et restaurer le bien-être physique et mental des Canadiens. En tant que groupe, les ministres provinciaux et territoriaux de la Santé acceptent l'existence d'une association coopérative avec le gouvernement fédéral basée d'abord sur les contributions que ce dernier verse au titre des soins et des services complémentaires de santé assurés.

Je dirais peut-être aussi que la Loi canadienne sur la santé ne constitue pas la réponse aux défis devant lesquels nous nous trouvons pour ce qui est de l'appareil de santé. Il me tarde de travailler avec vous dans un esprit de collaboration afin que nous puissions relever des défis comme l'évolution rapide de la technologie médicale et le vieillissement de la population, et que nous arrivions à définir des stratégies de promotion de la santé ainsi que d'autres formules pour assurer les soins.

Pour revenir à la tâche immédiate que représente l'application de la Loi canadienne sur la santé, je veux établir quelques énoncés raisonnablement complets de politique générale fédérale, à commencer par chacun des critères contenus dans la mesure législative.

Gestion publique

Le critère de la gestion publique est généralement accepté. Le but est de laisser la gestion des régimes provinciaux d'assurance-santé à une autorité publique, responsable devant le gouvernement provincial des décisions prises au sujet des seuils de prestations et des services, et assujettie à la vérification de ses dossiers et de ses comptes par une autorité publique.

Intégralité

La Loi canadienne sur la santé n'a pas pour but d'étendre ou de réduire la gamme de services assurés prévue dans l'ancienne législation fédérale. Sont compris dans les services assurés les soins hospitaliers nécessaires de l'avis d'un médecin, les services médicaux et les services de chirurgie dentaire qui doivent obligatoirement être dispensés à l'hôpital. Les régimes provinciaux doivent couvrir le coût des services aux malades hospitalisés et des services aux malades externes associés à la prestation des soins actifs, des soins de réadaptation et des soins aux malades chroniques. Pour ce qui est des services médicaux, les services assurés englobent généralement les services exigés pour des raisons médicales dispensés par des médecins autorisés de même que les interventions de chirurgie dentaire qui exigent l'hôpital pour être pratiquées comme il se doit. Les services dispensés par les autres professionnels des soins, sauf ceux qui doivent fournir les services hospitaliers nécessaires, ne sont pas assujettis aux critères de la Loi.

À l'intérieur de ces paramètres généraux, les provinces, de même que les médecins, ont le privilège et aussi la responsabilité de dire en quoi consistent les services médicaux nécessaires pour des raisons médicales. Ce sont aussi les provinces qui déterminent quels hôpitaux et quels services hospitaliers sont exigés pour fournir les soins actifs, les soins de réadaptation ou les soins aux malades chroniques.

Universalité

Le but de la Loi canadienne sur la santé est de garantir que tous les habitants reconnus d'une province ont droit à la protection et aux prestations en vertu d'un des douze régimes provinciaux ou territoriaux d'assurance-santé. Cependant les résidents éligibles ont la latitude et peuvent élire de ne pas adhérer au régime provincial.

L'accord sur l'admissibilité et la transférabilité fournit des directives utiles pour établir le domicile et déterminer les modalités qui permettent d'obtenir et de conserver la protection. Les dispositions en sont compatibles avec celles de la Loi.

Je veux dire quelques mots au sujet des primes. Les provinces ont incontestablement le droit de prélever des impôts et la Loi canadienne sur la santé n'entrave pas ce droit. La Loi n'interdit pas le système de primes en soi, pourvu que le régime provincial d'assurance-santé soit appliqué et géré de manière à ne pas refuser la protection ou empêcher l'accès aux services hospitaliers et aux services médicaux nécessaires pour les habitants reconnus d'une province. Les modalités administratives devraient être telles que les habitants ne soient pas privés de la protection parce qu'ils sont incapables de payer les primes.

Je suis conscient des problèmes auxquels font face certaines provinces dans le cas des touristes et des visiteurs qui peuvent avoir besoin de services de santé pendant leur séjour au Canada. Avec mes collègues du Cabinet, le ministre des Affaires extérieures et la ministre de l'Emploi et de l'Immigration, je veux effectuer un examen de ce qui se fait actuellement pour que tous les moyens soient pris afin d'informer les visiteurs éventuels de la nécessité de se protéger en se procurant une assurance-santé suffisante avant d'entrer au Canada.

En somme, je crois qu'en notre qualité de ministres de la Santé, nous avons tous l'obligation de poursuivre l'objectif, autrement dit, faire en sorte que toutes les personnes dûment domiciliées dans une province obtiennent et conservent le droit aux services assurés, et cela selon des modalités uniformes.

Transférabilité

Les dispositions de la Loi canadienne sur la santé relatives à la transférabilité visent à fournir aux assurés une protection ininterrompue en vertu de leur régime d'assurance-santé quand ils s'absentent temporairement de la province où ils sont domiciliés ou quand ils se déplacent d'une province à une autre. Pendant un séjour temporaire dans une autre province, les habitants reconnus d'une province ne devraient pas être obligés de payer de leur poche pour obtenir les services hospitaliers ou médicaux nécessaires. Les fournisseurs de soins devraient avoir l'assurance de toucher des montants raisonnables à l'égard du coût de ces services.

Quant aux services assurés reçus pendant un séjour à l'étranger, le but est de garantir une indemnisation raisonnable au titre des services hospitaliers ou médicaux d'urgence qui sont nécessaires ou des services prescrits qui n'existent pas dans une province ou dans les provinces voisines. En général, les formules de paiement rattachées aux indemnités qui auraient été versées au titre des mêmes services dispensés dans une province pourraient être acceptées pour les besoins de la Loi canadienne sur la santé.

Dans mes entretiens avec les ministres provinciaux et territoriaux, j'ai senti un désir d'arriver aux objectifs souhaités en matière de transférabilité et de réduire au minimum les difficultés que les Canadiens peuvent rencontrer quand ils se déplacent au Canada. Je crois que les ministres de la Santé des provinces et des territoires sont tous désireux de voir à ce que ces services soient fournis de façon plus efficace et d'une manière plus économique pour que les Canadiens puissent conserver leur protection d'assurance-santé ou obtenir les prestations ou les services sans empêchement indu.

Des progrès appréciables ont été réalisés ces dernières années grâce aux accords de réciprocité qui permettent d'atteindre les objectifs de transférabilité visés par la Loi canadienne sur la santé en ce qui a trait à la protection à l'intérieur du Canada. Ces accords ne font pas obstacle aux droits et privilèges des provinces quand il s'agit de déterminer quels sont les services rendus dans une autre province et d'en prévoir l'indemnisation. Ils n'empêchent pas non plus les provinces d'exercer un contrôle raisonnable par le moyen de l'approbation préalable des interventions facultatives. Mais je reconnais qu'il y a encore du travail à faire relativement aux modalités de paiement entre les provinces pour atteindre cet objectif, surtout par rapport aux services des médecins.

Je suis bien conscient que toutes les difficultés ne peuvent être résolues du jour au lendemain et qu'il faudra allouer assez de temps pour que les régimes provinciaux arrivent à ne pas exiger de frais directs des malades pour les services hospitaliers et les services médicaux nécessaires fournis dans les autres provinces.

Quant aux services nécessaires fournis à l'étranger, j'ai confiance que nous pouvons établir des normes acceptables d'indemnisation au titre des services médicaux et des services hospitaliers essentiels. La Loi ne définit pas de formule particulière et je serais heureux de connaître vos vues à ce sujet.

Pour que nos efforts s'harmonisent, je proposerais de demander au Comité consultatif fédéral-provincial des services médicaux et des services en établissement d'examiner différentes possibilités et de présenter d'ici un an des solutions pour atteindre ces objectifs.

Accessibilité raisonnable

La Loi est assez claire à l'égard de certains aspects de l'accessibilité. Ce qu'elle cherche à faire, c'est de décourager la pratique voulant que des frais soient exigés sur-le-champ pour les services assurés fournis aux assurés et d'empêcher que s'exercent de fâcheuses distinctions à l'égard d'un groupe de population en ce qui a trait à la facturation des services ou de l'usage nécessaire des services assurés. La loi met en même temps l'accent sur l'association qui doit exister entre les fournisseurs des services assurés et les gestionnaires des régimes provinciaux, exigeant que les régimes provinciaux comportent des mécanismes raisonnables de paiement ou d'indemnisation pour que les usagers aient un accès raisonnable aux services. Je veux souligner de nouveau mon intention de respecter les privilèges des provinces relativement à l'organisation, à l'émission d'un permis d'exercice, à l'offre, à la répartition de la main-d'oeuvre, ainsi qu'à l'affectation des ressources et aux priorités dans le cas des services assurés. Je tiens à vous assurer que le gouvernement fédéral ne recourra pas à la disposition relative à l'accès raisonnable pour intervenir directement dans des questions comme l'existence matérielle ou géographique des services ou la régie par les provinces des établissements et des professions qui fournissent les services assurés. Les grandes questions ayant trait à l'accès aux services de santé me seront inévitablement signalées. Je veux vous donner l'assurance que mon Ministère travaillera par l'intermédiaire des bureaux des ministres provinciaux et territoriaux, et de concert avec eux, afin de régler ces questions.

Mon but en vous faisant part de mes intentions au sujet des critères contenus dans la Loi canadienne sur la santé, c'est de nous permettre de travailler ensemble à définir notre système national d'assurance-santé. Je crois que si nous poursuivons le dialogue, si nous sommes favorables à l'idée d'échanger des renseignements et que nous voulons le faire, et si nous comprenons bien de part et d'autre les règles du jeu, nous pouvons mettre en oeuvre la Loi sans animosité et sans conflit.

Je préférerais que les ministres provinciaux et territoriaux aient eux-mêmes une possibilité d'interpréter les critères de la Loi canadienne sur la santé et de les appliquer à leurs régimes d'assurance-santé respectifs. Je crois également que les ministres de la Santé des provinces et des territoires comprennent et acceptent tous que j'ai des comptes à rendre au Parlement du Canada, et que je dois notamment présenter tous les ans un rapport sur le fonctionnement des régimes provinciaux d'assurance-santé en ce qui a trait au respect de ces critères fondamentaux.

Conditions

Cela m'amène aux conditions relatives à l'obligation de reconnaître les contributions fédérales et à celles de fournir des renseignements, l'une et l'autre pouvant être précisées dans le règlement. À ce propos, je veux me guider sur les principes suivants:

1. faire le moins de règlements possibles et seulement si c'est absolument nécessaire;

2. compter sur la bonne volonté des ministres pour reconnaître comme il se doit le rôle et la contribution du gouvernement fédéral et pour fournir de plein gré les renseignements nécessaires afin d'exécuter la Loi et de faire rapport au Parlement;

3. recourir à la concertation et à l'échange de renseignements qui nous profitent mutuellement comme moyens privilégiés pour mettre en oeuvre et faire appliquer la Loi canadienne sur la santé;

4. utiliser les mécanismes qui existent déjà pour échanger des renseignements à l'avantage mutuel de nos administrations.

En ce qui a trait à la reconnaissance des contributions fédérales à la santé par les gouvernements provinciaux et territoriaux, je suis convaincu que nous pouvons normalement arriver sans peine à nous entendre sur la solution appropriée. À mon avis, la meilleure formule, c'est de montrer qu'en tant que ministres de la Santé, nous travaillons ensemble dans l'intérêt du contribuable et du malade.

À l'égard de l'information, je m'en tiens à l'engagement que j'ai pris d'améliorer si possible les systèmes nationaux de données déjà en place, et cela dans un esprit de collaboration et de coopération. Ces systèmes servent à plus d'une fin et fournissent au gouvernement fédéral aussi bien qu'aux autres organismes et au grand public des données essentielles sur notre appareil de soins et l'état de santé de notre population. J'entrevois la poursuite d'un travail en association qui permettra d'améliorer les systèmes d'information sanitaire dans des domaines comme les taux de morbidité et de mortalité, l'état de santé, le fonctionnement des services de santé et leur utilisation, le coût et le financement des soins.

Je crois fermement que le gouvernement fédéral n'a pas besoin de réglementer ces questions. Je n'ai donc pas l'intention de recourir au pouvoir de réglementation pour ce qui est des renseignements exigés en vertu de la Loi canadienne sur la santé quand il s'agit d'étendre ou de modifier les systèmes généraux de données et les échanges de renseignements. Afin que l'information relative à la Loi canadienne sur la santé circule le plus économiquement possible, je vois seulement deux mécanismes particuliers, et essentiels, de transfert des données:

1. des estimations et des bilans sur la surfacturation et les frais modérateurs;

2. un bilan provincial annuel (peut-être sous la forme d'une lettre qui me sera envoyée) à présenter à peu près six mois après la fin de l'exercice financier, décrivant le fonctionnement des régimes provinciaux respectifs d'assurance-santé par rapport aux critères et aux conditions de la Loi canadienne sur la santé.

Au sujet du premier point, je propose d'établir des règlements dont le contenu sera identique à celui des règlements qui ont été acceptés pour 1985-86. Vous trouverez un projet de règlements joint à titre d'annexe I. Pour aider à préparer le bilan provincial annuel auquel je fais allusion au deuxième point, j'ai élaboré des directives générales qui constituent l'annexe II. Au-delà de ces documents bien précis, j'ai confiance que l'échange spontané et mutuellement bénéfique d'éléments tels que les lois, les règlements et les descriptions de programmes se poursuivra.

Une question a été soulevée au cours de nos entretiens antérieurs que nous avons eus au début, à savoir si les estimations ou les retenues en ce qui a trait aux frais modérateurs et à la surfacturation devraient être fondées sur les "montants facturés" ou sur les "montants perçus". La Loi établit clairement que les retenues doivent être basées sur les montants facturés. Or, en ce qui a trait aux frais modérateurs, des régimes provinciaux acquittent les frais indirectement pour certaines personnes. Lorsqu'il est nettement démontré qu'un régime provincial rembourse aux fournisseurs de soins le montant facturé mais ne le perçoit pas, disons à l'égard des bénéficiaires de l'aide sociale ou dans le cas des comptes impayés, il faudra rajuster en conséquence les estimations et les retenues.

Je veux insister sur le fait que lorsqu'un régime provincial n'autorise pas les frais modérateurs, tout le système doit être conforme au but du critère de l'accessibilité raisonnable énoncé à la page 6.

Règlements

En plus de ceux qui visent la reconnaissance du rôle fédéral et les renseignements à fournir, dont il est question précédemment, la Loi prévoit l'établissement de règlements ayant rapport aux services hospitaliers exclus et de règlements relatifs à la définition des services complémentaires de santé.

Vous êtes au courant que la Loi spécifie que chacune des provinces doit être consultée et qu'il doit y avoir entente au sujet des règlements. Les discussions que j'ai eues avec vous n'ont fait ressortir que certaines inquiétudes au sujet de l'ensemble provisoire de services exclus des règlements sur les services hospitaliers, ci-joint.

De même, je n'ai pas perçu d'inquiétude au sujet du projet de règlements qui définit les services complémentaires de santé. Ces règlements aident à fournir des précisions pour que les provinces puissent interpréter la Loi et gérer les régimes et programmes en cours. Ils ne modifient pas sensiblement ou en substance ceux qui ont été en vigueur pendant huit ans en vertu de la partie IV de la Loi de 1977 sur les contributions à l'enseignement postsecondaire et à la santé. Il se pourrait bien, cependant, quand nous commencerons à examiner les défis à relever dans le domaine des soins, que nous devions songer à revoir ces définitions.

J'ai voulu par cette lettre essayer d'établir des règles de base souples, raisonnables et claires pour faciliter à l'échelon provincial, aussi bien qu'à l'échelon fédéral, l'administration de la Loi canadienne sur la santé. J'ai voulu englober beaucoup de questions, dont l'interprétation des critères, la position fédérale au sujet des conditions et les projets de règlements. Je suis évidemment conscient qu'une lettre de cette sorte ne peut pas traiter de chacun des points qui préoccupent chaque ministre de la Santé. Il est donc essentiel qu'un dialogue et que la communication se poursuivent.

En terminant, laissez-moi vous remercier de l'aide que vous avez apportée pour en arriver à ce que je crois être un point de vue généralement accepté en ce qui a trait à l'interprétation et à l'application de la Loi. Tel que mentionné au début de cette lettre, je vous saurais gré de me signaler par écrit, sous peu vos vues sur les projets de règlements ci-joints. J'ai l'intention de vous écrire bientôt au sujet de l'échange volontaire de renseignements dont nous avons discuté, relativement à l'administration de la Loi et du rapport à présenter au Parlement.

Je vous prie d'agréer, Monsieur le Ministre, l'expression de ma considération distinguée.

Jake Epp

[Voici le texte de la lettre envoyée le 6 janvier 1995 à tous les ministres provinciaux et territoriaux de la Santé par l'honorable Diane Marleau, ministre de la Santé.]

Le 6 janvier 1995

Cher collègue,

Objet : la *Loi canadienne sur la santé*

La *Loi canadienne sur la santé* est en vigueur depuis un peu plus d'une décennie. Les principes énoncés dans la loi (gestion publique, intégralité, universalité, transférabilité et accessibilité) continuent d'être appuyés par tous les gouvernements provinciaux et territoriaux et par la grande majorité des Canadiens et des Canadiennes. Mais l'érosion possible du système de santé canadien administré et financé par le secteur public suscite des craintes, et il est essentiel de prendre les moyens nécessaires pour préserver ces principes.

Il est clair à la suite de la réunion de Halifax tenue récemment, que plusieurs ministres de la Santé sont préoccupés par une tendance à interpréter la loi de façons divergentes. J'aborderai d'autres questions à la fin de la présente lettre à cet égard. Toutefois, ma préoccupation principale concerne les cliniques privées et les frais d'établissement qu'elles perçoivent auprès de leurs patients. C'est un problème qui n'est pas nouveau pour les ministres de la Santé. Il a fait l'objet d'importantes discussions lors de note réunion à Halifax l'an dernier. Pour les raisons que j'expose dans cette lettre, je suis convaincue que la prolifération d'un «second palier» d'établissements, exploités entièrement ou dans une large mesure en dehors du système de santé administré et financé par des fonds publics, et dispensant des services médicalement nécessaires, constitue une menace sérieuse pour le système de soins de santé du Canada.

Plus précisément, et plus directement, je considère que les frais d'établissement exigés par les cliniques privées pour des services médicalement nécessaires représentent un problème sérieux qui doit être réglé. Selon moi, de tels frais constituent des frais modérateurs et à ce titre, ils contreviennent au principe de l'accessibilité de la *Loi canadienne sur la santé*.

Bien que ces frais d'établissement ne soient pas définis dans la loi fédérale, ni dans les dispositions législatives de la plupart des provinces, ce terme renvoie aux montants d'argent qui peuvent être exigés pour des services de type hospitalier dispensés en clinique et qui ne sont pas remboursés par la province, par opposition aux services fournis par un médecin. Lorsque ces frais d'établissement sont imposés pour des services médicalement nécessaires dispensés dans une clinique qui reçoit, par ailleurs, en vertu du régime d'assurance-santé de la province, des fonds publics pour la prestation de ces services, ces frais constituent un obstacle financier à l'accessibilité des services. Ils enfreignent par conséquent la disposition de la loi relative aux frais modérateurs (article 19).

Les frais d'établissement sont, à mon avis, inacceptables parce qu'ils limitent l'accès aux services médicalement nécessaires.

De plus, lorsque des cliniques qui reçoivent des fonds publics pour dispenser des services médicalement nécessaires exigent en supplément des frais d'établissement, les personnes qui ont les moyens de payer de tels frais sont directement subventionnées par tous les autres Canadiens et Canadiennes. Il m'apparaît tout à fait inacceptable de subventionner de la sorte un système de santé à deux paliers.

Ma position sur les frais d'établissement repose sur deux arguments. Le premier touche la politique en matière de santé. Dans le contexte actuel de la prestation des services de santé, une interprétation qui permet l'imposition de frais d'établissement pour des services médicalement nécessaires alors que le régime d'assurance-santé de la province couvre les honoraires du médecin va à l'encontre de l'esprit et de l'objet de la loi. Autrefois, de nombreux services médicaux exigeaient an séjour à l'hôpital; maintenant, grâce aux progrès de la technologie médicale et à la tendance à dispenser des services dans des endroits plus accessibles, il est possible d'offrir une vaste gamme de soins ou de services ambulatoires à l'extérieur du cadre hospitalier traditionnel. Le critère de la loi relatif à l'accessibilité, critère dont la disposition sur les frais modérateurs ne constitue qu'un exemple, avait, de toute évidence, pour objet de veiller à ce que les résidents du Canada reçoivent tous les services de santé médicalement nécessaires, sans obstacle financier ou autre, et quel que soit l'endroit où ces services sont dispensés. Ce critère doit conserver son sens initial quelle que soit la façon dont l'exercice de la médecine évolue.

Le deuxième argument relève de l'interprétation juridique. La définition du terme «hôpital» prévue dans la loi comprend tout établissement qui offre des soins hospitaliers aux personnes souffrant de maladie aiguë ou chronique ou exigeant des services de réadaptation. Cette définition couvre aussi les établissements de soins de santé connus sous le nom de «clinique». Pour des raisons touchant à la fois la politique et l'interprétation juridique, je considère donc que lorsqu'un régime d'assurance-santé provincial prévoit le paiement d'honoraires de médecin pour des services médicalement nécessaires dispensés dans une clinique, il doit également prévoir le paiement des services (hospitaliers) connexes associés à la prestation de ces services, sans quoi la province en question devra s'attendre à l'application de déductions correspondant au total des frais modérateurs.

Je me rends bien compte que cette interprétation nécessitera certaines modifications, particulièrement dans les provinces où des cliniques exigent actuellement des frais d'établissement applicables à des services de santé médicalement nécessaires. Afin d'éviter des difficultés qui pourraient être jugées déraisonnables, je fixe au 15 octobre 1995 la date de mise en application de cette interprétation. Les provinces disposeront ainsi du temps requis pour mettre en place les dispositions législatives ou réglementaires qui s'imposent. À compter du 15 octobre 1995, toutefois, je commencerai à déduire des paiements de transfert toute somme exigée pour des frais d'établissement lorsque des services de santé médicalement nécessaires sont en cause, comme le prévoit l'article 20 de la *Loi canadienne sur la santé*. À mon avis, les provinces bénéficieront ainsi d'une période de transition raisonnable étant donné qu'elles sont maintenant saisies de mes préoccupations concernant les cliniques privées, et compte tenu des progrès déjà réalisés par le Comité consultatif fédéral-provincial-territorial sur les services de santé qui se penche sur la question des cliniques privées depuis déjà un bon moment.

Je tiens à préciser que je ne cherche pas à empêcher l'utilisation de cliniques pour dispenser des services de santé médicalement nécessaires. Je sais que dans bien des cas, elles représentent un moyen efficace d'offrir des services de santé à moindre coût, et souvent en ayant recours à des techniques avancées. J'entends, par contre, veiller à ce que les services de santé médicalement nécessaires soient dispensés suivant des modalités uniformes et cela, quel que soit l'endroit ou ils sont offerts. Les principes de la *Loi canadiennes sur la santé* sont suffisamment souples pour permettre l'évolution de la médecine et de la prestation des soins de santé. Cependant, cette évolution ne saurait mener à la création d'un système de santé à deux paliers.

Comme je l'ai déjà mentionné dans cette lettre, même si la question des frais modérateurs constitue ma préoccupation immédiate, je m'inquiète également des questions plus générales soulevées par la prolifération des cliniques privées. Je crains que cette prolifération ne se traduise, à plus ou moins long terme, par une érosion de notre système de santé public, ce qui aurait pour résultat de limiter l'accès dont jouit la population canadienne aux services de santé médicalement nécessaires. L'énoncé de politique auquel la réunion d'Halifax a donné lieu, témoigne bien de ces préoccupations. Les ministres de la Santé présents, à l'exception de la Ministre de l'Alberta, ont convenu :

d'entreprendre toute démarche qui pourrait être nécessaire pour réglementer l'établissement des cliniques privées au Canada et maintenir un régime d'assurance-santé de grande qualité par les gouvernements.

La question des cliniques privées soulève de nombreuses préoccupations au sein du gouvernement fédéral, préoccupations que les provinces partagent. On s'inquiète entre autres :

- de l'affaiblissement de l'appui du public au système de santé administré et financé par l'État;
- de la diminution de la capacité des gouvernements de contrôler les coûts de la santé une fois que ceux-ci sont passés du secteur public au secteur privé;
- de la possibilité, comme en fait foi l'expérience vécue ailleurs, que les établissements privés concentrent leurs efforts sur les actes médicaux les plus faciles, laissant aux établissements publics le soin de s'occuper des cas plus complexes et plus coûteux;
- de la capacité qu'ont les établissements privés d'offrir aux professionnels de la santé des encouragements financiers susceptibles de les inciter à se désengager du système de santé public (incitant ces établissements à mobiliser leurs ressources financières afin d'attirer les consommateurs, plutôt que d'améliorer la qualité des soins offerts).

Le seul moyen de composer efficacement avec ces préoccupations consiste à réglementer l'exploitation des cliniques privées.

Je demande donc aux ministres de la Santé des provinces qui ne l'ont pas encore fait d'établir des cadres réglementaires régissant l'exploitation des cliniques privées. J'aimerais souligner que même si je me préoccupe surtout de l'élimination des frais modérateurs, il est tout aussi important que ces cadres réglementaires soient mis en place pour assurer un accès raisonnable aux services de santé médicalement nécessaires et pour favoriser la viabilité du système de santé financé et administré par l'État. À mon avis, il faut procéder sans tarder à leur mise en oeuvre.

N'hésitez pas à prendre contact avec moi pour des éclaircissements au sujet de ma position sur les cliniques privées et les frais d'établissement. Mes fonctionnaires, quant à eux, sont prêts à rencontrer les vôtres quand ils le souhaiteront pour en discuter. Il faudrait d'ailleurs selon moi, que nos fonctionnaires se concentrent, au cours des prochaines semaines, sur les préoccupations plus générales concernant les cliniques privées.

Comme je l'ai mentionné au début de la présente lettre, la *Loi canadienne sur la santé* fait l'objet d'interprétations divergentes touchant un bon nombre d'autres pratiques. Je préfère généralement que les problèmes touchant l'interprétation de la loi soient résolus par consensus fédéral-provincial-territorial en tenant compte des principes fondamentaux de la loi. J'ai, par conséquent, encouragé les deux paliers de gouvernement à tenir des consultations dans tous les cas où il y avait de tels désaccords. En ce qui a trait à des situations telles que la couverture des frais médicaux engagés hors de la province de résidence ou à l'étranger, j'ai l'intention de poursuivre les consultations dans la mesure où elles sont susceptibles de mener à des conclusions satisfaisantes, dans des délais raisonnables.

En terminant, j'aimerais citer monsieur le juge Emmett M. Hall qui nous rappelait en 1980 que :

> «...dans notre société, le traumatisme causé par les maladies, la douleur engendrée par les opérations chirurgicales et le lent acheminement vers la mort constituent suffisamment de fardeaux sans avoir à y ajouter celui qui provient des frais médicaux et hospitaliers frappant le malade au moment où il est vulnérable.»

Je suis convaincue, qu'en gardant cet avis à l'esprit, nous continuerons de conjuguer nos efforts en vue de sauvegarder et de renouveler ce qui pourrait bien être notre plus remarquable projet social.

Enfin, comme les questions traitées dans la présente lettre revêtent une importance certaine pour les Canadiens et Canadiennes, je compte la rendre publique une fois que tous les ministres provinciaux et territoriaux de la Santé l'auront reçue.

Veuillez agréer, cher collègue, l'expression de mes sentiments les meilleurs.

Diane Marleau
Ministre de la Santé

Annexe D – Retenues et remboursements effectués en vertu de la Loi canadienne sur la santé

Cette annexe donne des détails sur les retenues et les remboursements effectués sur les paiements de transfert provinciaux et territoriaux depuis l'entrée en vigueur de la *Loi canadienne sur la santé* en 1984.

Le tableau 1 présente les retenues annuelles effectuées sur les paiements de transfert par province et territoire, tandis que le tableau 2 résume l'ensemble des retenues et des remboursements effectués depuis l'entrée en vigueur de la *Loi*. En 2000-2001, des retenues s'élevant à 58 000 $ ont été effectuées sur les paiements versés à la Nouvelle-Écosse en vertu du Transfert canadien en matière de santé et de programmes sociaux. Ces retenues visaient l'imposition de frais modérateurs.

Les remboursements ont été accordés en vertu de l'article 20(5) durant les trois premières années d'application de la *Loi* aux provinces ayant supprimé la surfacturation et les frais modérateurs.

Tableau 1 – Retenues annuelles par province et territoire depuis l'entrée en vigueur de la *Loi canadienne sur la santé*

(en milliers de dollars)

Province ou territoire	1984-1985[1]		1985-1986[1]		1986-1987[1]		1987-1992		1992-1993		1993-1994		1994-1995	
	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.
Terre-Neuve et Labrador							Aucune retenue durant cette période							
Île-du-Prince-Édouard														
Nouvelle-Écosse														
Nouveau-Brunswick	63	3 015	84	3 222	206	296								
Québec		7 893		6 139										
Ontario	39 996		55 328		13 332									
Manitoba	810		460											
Saskatchewan	1 451		656											
Alberta	8 109	1 827	9 216	2 640	5 878	1 362								
Colombie-Britannique		22 797		30 620		31 332			83		1 223		676	
Yukon														
Territoires du Nord-Ouest														
Nunavut														
Total prov. et terr.	**50 429**	**35 532**	**65 744**	**42 621**	**19 416**	**32 990**			**83**		**1 223**		**676**	

[1] Ces fonds ont été par la suite remboursés en vertu de l'article 20(5) de la *Loi canadienne sur la santé* pour les retenues effectuées pour la surfacturation et les frais modérateurs durant la période allant de 1984-1985 à 1986-1987.

Tableau 1 – Retenues annuelles par province et territoire depuis l'entrée en vigueur de la *Loi canadienne sur la santé* (suite)

(en milliers de dollars)

Province ou territoire	1995-1996		1996-1997		1997-1998		1998-1999		1999-2000		2000-2001		Retenues totales brutes de 1984-1985 à 2000-2001		
	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Surfacturation	Frais modér.	Total
Terre-Neuve et Labrador		46		96		128		53						323	323
Île-du-Prince-Édouard															
Nouvelle-Écosse		32		72		57		39		61[2]		58		319	319
Nouveau-Brunswick													353	6 533	6 886
Québec														14 032	14 032
Ontario													108 656		108 656
Manitoba		269		588		587		612					1 270	2 056	3 326
Saskatchewan													2 107		2 107
Alberta		2 319		1 266									23 203	9 414	32 617
Colombie-Britannique	43												2 025	84 749	86 774
Yukon															
Territoires du Nord-Ouest															
Nunavut															
Total prov. et terr.	43	2 666		2 022		772		704		61		58	137 614	117 426	255 040

[2] Il s'agit d'une révision des chiffres publiés dans le *Rapport annuel sur la Loi canadienne sur la santé* pour 1999-2000.

Tableau 2 – Résumé des retenues et remboursements par province et territoire depuis l'entrée en vigueur de la *Loi canadienne sur la santé*

(en milliers de dollars)

Province ou territoire	Retenues totales brutes de 1984-1985 à 2000-2001			Remboursements liés aux retenues de 1984-1985 à 1986-1987			Retenues totales nettes de 1984-1985 à 2000-2001		
	Surfacturation	Frais modér.	Total	Surfacturation	Frais modér.	Total	Surfacturation	Frais modér.	Total
Terre-Neuve et Labrador		323	323					323	323
Île-du-Prince-Édouard									
Nouvelle-Écosse		319	319					319	319
Nouveau-Brunswick	353	6 533	6 886	(353)	(6 533)	(6 886)			
Québec		14 032	14 032		(14 032)	(14 032)			
Ontario	108 656		108 656	(108 656)		(108 656)			
Manitoba	1 270	2 056	3 326	(1 270)		(1 270)			
Saskatchewan	2 107		2 107	(2 107)		(2 107)		2 056	2 056
Alberta	23 203	9 414	32 617	(23 203)	(5 829)	(29 032)			
Colombie-Britannique	2 025	84 749	86 774		(84 479)	(84 749)		3 585	3 585
Yukon							2 025		2 025
Territoires du Nord-Ouest									
Nunavut									
Total prov. et terr.	137 614	117 426	255 040	(135 589)	(111 143)	(246 732)	2 025	6 283	8 308

Annexe E – Évolution des transferts fédéraux et Transfert canadien en matière de santé et de programmes sociaux

Depuis que le gouvernement fédéral a commencé à contribuer aux régimes provinciaux et territoriaux d'assurance-santé en 1958, les accords visant ces contributions ont évolué. Avant 1977, le gouvernement fédéral partageait les frais des services hospitaliers et des services médicaux avec les provinces et les territoires. En 1977, le partage des frais a été remplacé par un financement global (Financement des programmes établis – FPE). Le 1er avril 1996, le Transfert canadien en matière de santé et de programmes sociaux (TCSPS) a remplacé le FPE et le Régime d'assistance publique du Canada (RAPC); le TCSPS continue à soutenir, par des transferts de fonds et des transferts fiscaux, les programmes de santé et les autres programmes sociaux fournis par les provinces et les territoires. Ces accords sont décrits dans la section qui suit. Des renseignements supplémentaires au sujet des programmes et des accords fiscaux fédéraux sont disponibles auprès du ministère des Finances.

Partage des frais

À l'origine, la contribution fédérale aux régimes d'assurance-hospitalisation provinciaux et territoriaux était fonction des montants déboursés par les provinces et les territoires pour offrir des services hospitaliers assurés. En vertu de la *Loi sur l'assurance-hospitalisation et les services diagnostiques* (1957), le gouvernement fédéral remboursait aux provinces et aux territoires environ 50 p. 100 des coûts de l'assurance-hospitalisation. De même, en vertu de la *Loi sur les soins médicaux* (adoptée en 1966 et entrée en vigueur en 1968), la contribution fédérale au soutien des soins médicaux était égale à la moitié du coût moyen national par habitant pour les services assurés, multipliée par le nombre de personnes assurées dans chaque province et territoire.

Financement des programmes établis (FPE)

En 1977, les accords de partage des frais ont été remplacés par le FPE. À la différence des accords de partage des frais antérieurs, le FPE était un système de financement global et n'était plus illimité, même si le financement – dès le début du FPE et durant presque toute son existence – était calculé en fonction de la croissance économique, à l'aide de diverses formules.

Sous le régime du FPE, des transferts de fonds et des transferts fiscaux étaient consentis aux provinces et aux territoires à l'appui des programmes de santé et d'enseignement postsecondaire. Exception faite des premières années, le FPE (transferts de fonds et transferts fiscaux) était réparti selon la formule du montant égal par habitant.

Les transferts fiscaux étaient calculés d'après la valeur des points d'impôt transférés par le gouvernement fédéral aux provinces et aux territoires en 1977 (13,5 points d'impôt sur le revenu des particuliers et un point d'impôt sur le revenu des sociétés).

Les fonds en espèces au titre du FPE étaient transférés chaque mois à la province ou au territoire, si le régime provincial ou territorial avait respecté les conditions d'octroi et de versement de la *Loi canadienne sur la santé*.

En 1995-1996, la dernière année du FPE, les provinces et les territoires ont reçu au total (transferts de fonds et transferts fiscaux confondus) 22 milliards de dollars au titre du FPE, dont 71,2 pour cent pour les soins de santé et le reste pour l'enseignement postsecondaire.

Transfert canadien en matière de santé et de programmes sociaux (TCSPS)

Dans son budget de 1995, le gouvernement fédéral annonçait un régime de partage des frais pour les services sociaux, le TCSPS, qui remplaçait les transferts du FPE et du RAPC. Lorsque le TCSPS est entré en vigueur en 1996, les provinces et les territoires touchaient la même part en vertu du TCSPS qu'en vertu du RAPC, et la même part du financement de la santé et de l'enseignement postsecondaire qu'en vertu du FPE. La répartition provinciale-territoriale établie sous le régime des programmes antérieurs demeurait la même sous le TCSPS, mais a été rajustée graduellement afin de mieux tenir compte de la distribution de la population des provinces et des territoires.

Le TCSPS est un financement global, qui combine des transferts de fonds et des transferts fiscaux aux gouvernements provinciaux et territoriaux, au titre de la santé, de l'enseignement postsecondaire, et des programmes de services sociaux et d'aide sociale.

En 2000-2001, les paiements au titre du TCSPS ont été de 32 milliards de dollars, sous forme de transferts de fonds et de transferts fiscaux (Source : ministère des Finances, octobre 2001).

Versement des paiements au titre du TCSPS

Le ministère des Finances assure le versement des paiements du TCSPS aux provinces et aux territoires depuis le 1er avril 1996. Cependant, le ministre de la Santé demeure responsable de déterminer le montant des retenues à effectuer en vertu de la *Loi canadienne sur la santé*, y compris de celles concernant la surfacturation et les frais modérateurs, et de communiquer ces montants au ministère des Finances avant les dates de paiement. Le ministère des Finances fait ensuite les retenues effectives sur les paiements bimensuels versés au titre du TCSPS aux provinces et aux territoires.

Annexe F – Lexique des termes utilisés dans le présent rapport

Les termes compris dans le présent glossaire sont définis dans le contexte de la Loi canadienne sur la santé. *Ils peuvent être définis ou interprétés différemment dans d'autres situations.*

Terme	Explication
Absence temporaire	Absence de la province ou du territoire d'origine, motivée par le travail, les études, les vacances ou d'autres raisons qui ne supposent pas que la personne établira sa résidence permanente ailleurs.
Accessibilité	La condition d'accessibilité de la *Loi canadienne sur la santé* (article 12) suppose que le régime provincial ou territorial d'assurance-santé : • offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, à un accès raisonnable des assurés à ces services; • prévoie la prise en charge des services de santé assurés selon un mode de paiement autorisé par la loi de la province ou du territoire; • prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes; • prévoie le versement de montants aux hôpitaux à l'égard du coût des services de santé assurés.
Accord sur l'admissibilité et la transférabilité	Le premier Accord interprovincial-territorial sur l'admissibilité et la transférabilité a été approuvé par les ministres fédéral, provinciaux et territoriaux de la Santé en 1971 et mis en place en 1972. L'Accord fixe les normes minimales relatives à l'admissibilité et à la transférabilité interprovinciales-territoriales des régimes d'assurance-santé. Les provinces et les territoires appliquent de leur plein gré les dispositions de l'Accord, facilitant ainsi la mobilité des Canadiens et leur accès aux services de santé partout au Canada. Les provinces et les territoires se réunissent périodiquement pour examiner et réviser l'Accord.
Admission	Acceptation officielle dans un établissement de santé d'une personne qui requiert, pour une période donnée, des services médicaux ou de santé et l'assignation d'un lit à cette personne.
Caisse supplémentaire d'assurance-santé	Caisse, administrée par la Division de la Loi canadienne sur la santé, qui aide les personnes qui ont perdu ou qui n'ont pu obtenir, sans qu'elles en soient responsables, la protection d'un régime d'assurance-santé provincial ou territorial pour les services de santé assurés en vertu de la *Loi canadienne sur la santé*.
Chirurgie d'un jour	Intervention chirurgicale en milieu hospitalier, qui n'exige pas que le malade passe la nuit à l'hôpital pour le suivi post-opératoire ou pour la récupération.

Terme	Explication
Comité de coordination de la facturation réciproque (CCFR)	Formé en 1991, le Comité de coordination de la facturation réciproque (CCFR) regroupe des fonctionnaires fédéraux, provinciaux et territoriaux du domaine de la santé. Il est chargé de cerner et de résoudre les problèmes administratifs découlant des ententes de facturation interprovinciales et interterritoriales pour les services hospitaliers et médicaux (rendus par un médecin). L'objectif général des accords de facturation réciproque provinciaux-territoriaux est d'assurer que les Canadiens admissibles aient accès aux services de santé médicalement nécessaires lorsqu'ils doivent se rendre à l'extérieur de leur province ou territoire pour recevoir ces services, lorsqu'ils voyagent, ou lorsqu'ils sont en congé d'études ou occupent un emploi temporaire.
Condition de communication des renseignements	La *Loi canadienne sur la santé* (article 13(a)) stipule que les gouvernements provinciaux et territoriaux doivent communiquer au ministre fédéral de la Santé, selon des modalités raisonnables, des renseignements touchant les services de santé assurés et les services complémentaires de santé aux fins de l'application de la *Loi*.
Condition de gestion publique	Cette condition de la *Loi canadienne sur la santé* (article 8) exige que les régimes d'assurance-santé provinciaux et territoriaux soient gérés et exploités sans but lucratif par une autorité publique qui doit rendre des comptes au gouvernement de la province ou du territoire, et qui est assujettie à la vérification de ses comptes et de ses opérations financières.
Condition de reconnaissance	La *Loi canadienne sur la santé* (article 13(b)) stipule que les provinces et les territoires doivent faire état du Transfert canadien en matière de santé et de programmes sociaux dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province ou le territoire.
Coût quotidien moyen des soins aux malades hospitalisés	Estimation du montant qu'une province ou un territoire établit comme étant le coût quotidien moyen pour un traitement ou un séjour en établissement de soins de santé.
Demandeur du statut de réfugié	Personne qui est entrée au Canada et qui demande le statut de réfugié. Si l'on détermine qu'un demandeur du statut de réfugié est un réfugié au sens de la Convention, cette personne peut demander le statut de résident permanent.
Durée de séjour	Nombre de jours pendant lesquels un patient est hospitalisé.
Entente de facturation réciproque des soins hospitaliers	Entente bilatérale conclue entre des provinces ou des territoires, qui autorise le traitement réciproque de demandes de remboursement de la province ou du territoire pour des services hospitaliers offerts à des malades hospitalisés et externes. En vertu d'une telle entente, les services hospitaliers assurés sont remboursables aux taux approuvés par la province ou le territoire d'accueil, ou comme il a été convenu par les parties en cause et le Comité de coordination de la facturation réciproque (CCFR).
Entente de facturation réciproque des soins médicaux	Entente bilatérale conclue entre des provinces ou des territoires, qui autorise le traitement réciproque de demandes de remboursement pour des services médicaux reçus à l'extérieur de la province ou du territoire d'origine et fournis par un médecin autorisé. En vertu d'une telle entente, les services médicaux assurés sont remboursables aux taux approuvés par la province ou le territoire d'accueil.

Terme	Explication
Établissement de chirurgie externe	Établissement de soins de santé qui fournit des services de chirurgie de courte durée (chirurgie d'un jour seulement).
Établissement de chirurgie privé	Établissement de soins de santé privé offrant des services de chirurgie.
Établissement de diagnostic privé	Établissement de soins de santé privé offrant des services de laboratoire et de radiologie, et d'autres services de diagnostic.
Établissement de santé privé (sans but lucratif)	Établissement de soins de santé privé qui est reconnu comme un organisme à but non lucratif en vertu des lois du gouvernement fédéral, ou du gouvernement provincial ou territorial en cause.
Établissement de santé privé (à but lucratif)	Établissement de soins de santé privé qui distribue des dividendes à ses propriétaires, actionnaires, exploitants ou membres, ou qui partage les profits avec eux.
Établissement de soins actifs	Établissement de santé où sont fournis des soins ou des traitements aux patients souffrant d'une maladie aiguë ou dont l'état de santé est grave.
Établissement de soins de longue durée	Établissement qui fournit des services médicaux continus et de longue durée à des malades hospitalisés. Les établissements de soins chroniques ne comprennent pas les maisons de repos.
Établissement de soins de santé	Bâtiment ou groupe de bâtiments faisant partie d'une structure organisationnelle commune, qui loge le personnel ou l'équipement de soins de santé servant à fournir des services de santé (p. ex., diagnostic, chirurgie, soins actifs, soins de longue durée, soins dentaires, physiothérapie) à l'ensemble de la population ou à un groupe particulier de personnes ou de résidents.
Établissement de soins de santé public	Établissement de soins de santé situé au Canada et administré par le secteur public, qui offre des services de santé assurés par le régime public à des malades externes et hospitalisés.
Étapes de la consultation	En vertu de l'article 14(2) de la *Loi canadienne sur la santé*, le ministre de la Santé doit consulter la province ou le territoire concerné au sujet d'un manquement potentiel aux cinq conditions d'octroi et aux deux conditions de versement de la *Loi*, avant que des retenues discrétionnaires soient imposées à la province ou au territoire.
Financement des programmes établis (FPE)	Adoptée en 1977, la *Loi sur les accords fiscaux entre le gouvernement fédéral et les provinces et sur le financement des programmes établis*, également connue sous le nom de *Loi FPE*, a remplacé les programmes fédéraux de partage des frais déboursés par les provinces et territoires pour les services médicaux et hospitaliers assurés et pour l'enseignement postsecondaire. Le FPE était un système de financement global lié à la croissance économique et démographique. En vertu du FPE, des transferts de fonds et des transferts fiscaux étaient consentis aux provinces et aux territoires pour financer les services de santé et d'enseignement postsecondaire. En 1996, le FPE a été remplacé par le Transfert canadien en matière de santé et de programmes sociaux.
Frais de fournitures médicales	Frais imposés pour des articles, tels que les tampons alcoolisés, les instruments, les fils de suture, qui sont utilisés pour la prestation d'un service médical assuré.

Terme	Explication
Frais modérateurs	Tous les frais pour un service de santé assuré qui sont autorisés ou permis par un régime d'assurance-santé provincial ou territorial mais que ce dernier ne rembourse pas directement ou indirectement, à l'exception des frais imposés par surfacturation.
Habitant	Voir « Résident ».
Honoraires forfaitaires	Frais imposés par un médecin pour des services non couverts par le régime d'assurance-santé provincial ou territorial, tels les consultations téléphoniques, le renouvellement d'ordonnances par téléphone et la préparation de formulaires et de documents.
Hôpital	Établissement de soins de santé situé au Canada où sont fournis des services médicaux et de chirurgie, ou des traitements aux personnes malades ou blessées, y compris des soins actifs, de longue durée et de réadaptation, à l'exception des établissements destinés principalement aux personnes souffrant de troubles mentaux, et des établissements ou des unités des établissements où sont fournis des soins intermédiaires en maison de repos, des soins en établissement pour adultes ou des soins comparables pour les enfants.
Intégralité	Condition de la *Loi canadienne sur la santé* (article 9) qui oblige les régimes provinciaux ou territoriaux d'assurance-santé à couvrir tous les services de santé assurés (hospitaliers, médicaux ou de chirurgie dentaire) et, lorsque la loi de la province ou du territoire le prévoit, les services fournis par d'autres professionnels de la santé.
Lettre « Epp »	En juin 1985, le ministre fédéral de la Santé et du Bien-être social, M. Jake Epp, a confirmé la politique fédérale d'interprétation et d'application de la *Loi canadienne sur la santé* dans une lettre aux provinces et aux territoires. La lettre « Epp » (annexe C) demeure une référence importante pour l'interprétation de la *Loi*.
Lit pour soins de longue durée	Lit réservé aux malades hospitalisés ayant besoin de services médicaux continus et de longue durée.
Lit pour chirurgie d'un jour	Lit réservé aux services de chirurgie à court terme (c.-à-d. moins de 24 heures).
Lit pour soins actifs	Lit d'un établissement de soins de santé réservé à des malades hospitalisés recevant un traitement ou des soins pour une maladie aiguë ou un problème de santé grave.
Lits dotés en personnel	Nombre de lits pour lesquels un établissement de soins de santé dispose de personnel affecté à la prestation de services de santé.
Lit pour soins de réadaptation	Lit réservé aux malades requérant une hospitalisation pour la prestation de soins de réadaptation (p. ex., réadaptation pour traumatismes médullaires ou crâniens).

Terme	Explication
Loi canadienne sur la santé	La *Loi canadienne sur la santé* a reçu la sanction royale le 17 avril 1984, avec l'appui unanime de la Chambre des communes et du Sénat. La *Loi*, qui remplace la *Loi sur l'assurance-hospitalisation et les services diagnostiques* (1957) et la *Loi sur les soins médicaux* (1968), énonce les normes nationales que les régimes d'assurance-santé provinciaux et territoriaux doivent respecter afin de recevoir la pleine contribution en espèces du gouvernement fédéral, prévue dans le cadre du Transfert canadien en matière de santé et de programmes sociaux.
Malade externe	Personne admise dans un hôpital, une clinique ou un autre établissement de santé pour un traitement qui ne nécessite pas un séjour d'une nuit.
Malade hospitalisé	Personne admise dans un hôpital, une clinique ou un autre établissement de santé pour un traitement qui nécessite l'hospitalisation pour au moins une nuit.
Médecin	Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.
Médecin ayant opté pour le retrait du régime d'assurance-santé	Médecin ayant opté pour le retrait du régime d'assurance-santé, de sorte qu'il facture ses patients directement selon le taux provincial ou territorial. Conformément à l'entente touchant le barème des honoraires, le régime provincial ou territorial rembourse ces patients jusqu'à concurrence du montant prévu par le régime pour les services rendus.
Médecin non participant	Médecin qui ne participe d'aucune façon au régime d'assurance-santé provincial ou territorial. Dans ce cas, ni le médecin ni le patient n'est admissible, en vertu du régime d'assurance-santé provincial ou territorial, à une couverture pour les services rendus ou reçus. Un médecin non participant peut donc fixer ses propres honoraires, lesquels sont payés directement par le patient.
Médecin ou dentiste participant	Médecin ou dentiste autorisé qui est inscrit à un régime provincial ou territorial d'assurance-santé.
Nombre total de lits approuvé	Nombre de lits qu'un établissement est autorisé à ouvrir en vue de répondre aux attentes en matière de prestation de services de santé. L'autorisation est accordée par la province, le territoire, ou le gouvernement fédéral dans le cas d'un hôpital fédéral.
Omnipraticien	Médecin autorisé qui exerce la médecine à l'échelle communautaire dans une province ou un territoire et qui renvoie les patients à des spécialistes lorsque le diagnostic posé le justifie.
Pénalités discrétionnaires	Voir « Retenues discrétionnaires ».
Pénalités obligatoires	Voir « Retenues obligatoires ».

Terme	Explication
Politique fédérale sur les cliniques privées (lettre « Marleau »)	Le 6 janvier 1995, la ministre fédérale de la Santé, M^me^ Diane Marleau, a écrit à toutes les provinces et à tous les territoires pour leur communiquer l'interprétation fédérale en ce qui concerne l'inclusion des cliniques privées dans la définition d'« hôpital » dans la *Loi canadienne sur la santé*. La lettre précisait que la définition d'« hôpital » s'étendait à tout établissement qui fournissait des soins actifs, de réadaptation ou de longue durée, y compris les « cliniques ». Elle les informait également de son intention de considérer les frais d'établissement chargés aux patients par ces établissements et cliniques comme des frais modérateurs. L'imposition de frais modérateurs contrevient à la *Loi canadienne sur la santé* et entraîne la retenue d'une partie des transferts de fonds versés à chaque province et territoire. L'annexe C du présent rapport renferme une copie de cette lettre.
Personne assurée	En vertu de la *Loi canadienne sur la santé*, une « personne assurée » est un résident d'une province ou d'un territoire, à l'exception : • des membres des Forces canadiennes; • des membres de la Gendarmerie royale du Canada nommés à un grade; • des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la partie I de la *Loi sur les pénitenciers;* • des personnes qui ne sont pas installées dans la province ou le territoire depuis assez longtemps pour satisfaire à la condition du délai minimal de résidence ou de carence d'au plus trois mois qui les rendrait admissibles ou qui leur donnerait droit aux services de santé assurés.
Produits et services médicaux améliorés	Produits ou services médicaux fournis de pair avec des services assurés. Il s'agit généralement d'un service ou d'un produit de qualité supérieure qui n'est pas médicalement nécessaire et qui est offert à un patient l'ayant choisi à cause d'une préférence personnelle ou de la commodité du produit.
Radiations	Nombre total de malades hospitalisés et de malades externes qui quittent un établissement de santé à la suite d'un congé, d'un transfert, d'une chirurgie d'un jour ou d'un décès.
Réfugié au sens de la Convention	Toute personne qui craint avec raison d'être persécutée dans son pays d'origine du fait de sa race, de sa religion, de sa nationalité, de son appartenance à un groupe social ou de ses opinions politiques. Au Canada, la Commission de l'immigration et du statut de réfugié, Section du statut de réfugié, décide de l'octroi du statut de réfugié au sens de la Convention.
Régime d'assurance-santé	Le régime ou les régimes constitués par la loi d'une province ou d'un territoire en vue de la prestation de services de santé assurés.
Règlement concernant les renseignements sur la surfacturation et les frais modérateurs	Le *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs* de la *Loi canadienne sur la santé* (voir l'annexe B) prévoit, pour les provinces et les territoires qui autorisent la surfacturation et la perception de frais modérateurs, des retenues obligatoires, d'un montant équivalent, sur les paiements de transfert fédéraux.
Rémunération à l'acte	Mode de paiement utilisé par les médecins et reposant sur un barème d'honoraires qui précise le coût de chaque service.

Terme	Explication
Résident	Personne domiciliée et résidant habituellement dans une province ou un territoire, et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme ou étant de passage ou en visite dans la province ou le territoire.
Retenues obligatoires	Les provinces qui permettent la surfacturation ou l'application de frais modérateurs se verront imposer une retenue obligatoire, d'un montant équivalent, sur les paiements de transfert fédéraux. Les retenues obligatoires sont décrites dans les articles 20 et 21 de la *Loi canadienne sur la santé*. En vertu de ces dispositions, le ministre fédéral de la Santé peut autoriser que l'on réduise les paiements de transfert à une province ou à un territoire en vertu du Transfert canadien en matière de santé et de programmes sociaux si l'on relève une violation des dispositions relatives à la surfacturation ou aux frais modérateurs et si l'on ne peut résoudre le problème par la consultation entre les deux paliers de gouvernement.
Retenues discrétionnaires	Les retenues discrétionnaires sont énoncées dans les articles 14 à 17 de la *Loi canadienne sur la santé*. En vertu des dispositions de la *Loi*, le ministre fédéral de la Santé peut autoriser, conformément au Transfert canadien en matière de santé et de programmes sociaux, une réduction des paiements fédéraux destinés à une province ou à un territoire qui ne satisfait pas aux cinq conditions d'octroi et aux deux conditions de versement énoncées dans la *Loi canadienne sur la santé*, lorsque ces manquements ne peuvent être autrement résolus par des consultations entre les paliers respectifs de gouvernement. Les montants de ces retenues sont établis en fonction de la gravité du manquement.
Service de chirurgie dentaire assuré	La *Loi canadienne sur la santé* définit un service de chirurgie dentaire comme tout acte de chirurgie dentaire nécessaire sur le plan médical ou dentaire et accompli par un dentiste dans un hôpital, et qui ne peut être accompli convenablement qu'en un tel établissement.
Service de chirurgie rendu par un médecin	Aux fins du rapport sur l'application de la *Loi canadienne sur la santé*, un service de chirurgie rendu par un médecin est un service de chirurgie nécessaire sur le plan médical et rendu par un médecin.
Service de diagnostic rendu par un médecin	Service médicalement nécessaire fourni par un médecin qui décèle ou détermine la présence de maladies ou de problèmes de santé.
Service médical	Aux fins de la *Loi canadienne sur la santé*, tout service médicalement nécessaire fourni par un médecin.
Service médical assuré	Service médicalement nécessaire couvert par un régime d'assurance-santé provincial ou territorial et fourni par un médecin.
Services complémentaires de santé	D'après l'article 2 de la *Loi canadienne sur la santé*, ces services comprennent : les soins intermédiaires en maison de repos, les soins en établissement pour adultes, les soins à domicile et les soins ambulatoires.
Services de diagnostic aux malades externes	Services de santé fournis dans un établissement de soins de santé pour un traitement ne nécessitant pas un séjour d'une nuit et qui a pour objet de dépister ou d'identifier diverses maladies ou affections.

Terme	Explication
Service de santé assurés	En vertu de la *Loi canadienne sur la santé*, un service de santé assuré est un service hospitalier, médical ou de chirurgie dentaire fourni à un assuré, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.
Services hospitaliers assurés	En vertu de la *Loi canadienne sur la santé*, services fournis dans un hôpital ou un établissement de santé aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic, ou le traitement des blessures, maladies ou invalidités, à savoir : • l'hébergement et la fourniture des repas en salle commune ou, si c'est médicalement nécessaire, en chambre privée ou semi-privée; • les services infirmiers; • les procédures de laboratoire, de radiologie ou les autres procédures diagnostiques, ainsi que les interprétations nécessaires; • les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital; • l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires; • les fournitures et le matériel médicaux et chirurgicaux; • l'usage des installations de radiothérapie; • l'usage des installations de physiothérapie; • les services fournis par les personnes rémunérées à cet effet par l'hôpital ou l'établissement de soins de santé.
Services médicaux	Aux fins de la *Loi canadienne sur la santé*, les services médicaux renvoient à tous les services médicalement nécessaires fournis par des médecins.
Soins actifs	Ces soins comprennent les services de santé offerts aux personnes souffrant d'une maladie grave et soudaine, et qui doivent recevoir des soins infirmiers professionnels et être sous observation professionnelle de manière continue. Parmi les exemples de soins actifs, on compte l'observation postopératoire dans une unité de soins intensifs, et les services de soins et d'observation pendant l'attente d'une chirurgie d'urgence.
Soins de longue durée	Soins requis par une personne souffrant d'une maladie chronique ou d'une déficience fonctionnelle (physique ou mentale), qui a traversé la phase aiguë de la maladie, dont les processus vitaux peuvent ou non être stables et qui a besoin d'une gamme de services et de traitements médicaux ne pouvant être fournis que dans un hôpital.
Soins de réadaptation	Services de santé offerts à des personnes ayant besoin d'une aide professionnelle pour restaurer des habiletés physiques et fonctionnelles à la suite d'une maladie ou d'une blessure (p. ex., physiothérapie et orthophonie à la suite d'un accident cérébrovasculaire).
Spécialiste	Médecin autorisé exerçant la médecine dans une province ou un territoire et dont la tâche principale consiste à poser des diagnostics spécialisés et à offrir des traitements spécialisés. Parmi les spécialités, on compte, entre autres, l'anesthésie, la dermatologie, la chirurgie générale, la gynécologie, la médecine interne, la neurologie, la neuropathologie, l'ophtalmologie, la pédiatrie, la chirurgie plastique, la radiologie et l'urologie.

Terme	Explication
Surfacturation	Facturation de la prestation d'un service de santé assuré à une personne assurée par un médecin ou un dentiste, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial ou territorial d'assurance-santé.
Tiers payeurs	Commissions d'indemnisation des accidents du travail, compagnies d'assurance-santé privées, régimes d'assurance-santé d'un employeur ou autres entités qui remboursent des services de santé assurés à leurs clients ou à leurs employés.
Transférabilité	Cette condition de la *Loi canadienne sur la santé* (article 11) exige que les régimes d'assurance-santé provinciaux et territoriaux n'imposent pas de délai minimal de résidence ou de carence supérieur à trois mois aux résidents de la province ou du territoire pour qu'ils soient admissibles ou aient droit aux services de santé assurés. En outre, les régimes doivent couvrir et payer les services assurés fournis aux personnes assurées temporairement absentes de la province ou du territoire, et durant toute période de résidence ou de carence imposée par le régime d'assurance-santé d'une autre province ou d'un autre territoire.
Transfert canadien en matière de santé et de programmes sociaux (TCSPS)	Le Transfert canadien en matière de santé et de programmes sociaux représente le plus important transfert fédéral aux provinces et aux territoires. Il prend la forme de transferts de fonds et de transferts fiscaux visant à soutenir les programmes de santé, d'enseignement postsecondaire, d'aide sociale et de services sociaux. Le volet fiscal du TCSPS est entré en vigueur en 1997, lorsque le gouvernement fédéral a accepté de prélever moins d'impôt sur le revenu des particuliers et des sociétés, permettant ainsi aux provinces et aux territoires d'augmenter leurs taux d'imposition d'un montant égal. C'est ainsi que les impôts qui auraient été prélevés par le gouvernement fédéral se sont retrouvés dans les coffres des provinces et des territoires.
Universalité	Cette condition de la *Loi canadienne sur la santé* (article 10) exige qu'au titre d'un régime d'assurance-santé provincial ou territorial, 100 p. 100 des assurés de la province ou du territoire aient droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

Coordonnées des ministères provinciaux et territoriaux de la Santé

Terre-Neuve et Labrador
Régime d'assurance-soins médicaux
B.P. 200, Tours Elizabeth
100, avenue Elizabeth
St. John's (Terre-Neuve et Labrador) A1C 5J3
(709) 292-4000
www.gov.nf.ca/mcp/

Île-du-Prince-Édouard
Directeur, Soins actifs et soins de longue durée
16, rue Garfield
B.P. 2000
Charlottetown (Île-du-Prince-Édouard) C1A 7N8
(902) 368-6184
www.gov.pe.ca/hss/aacc-info/

Nouvelle-Écosse
Directeur, Initiatives interorganismes
Bureau du sous-ministre
Ministère de la Santé de la Nouvelle-Écosse
B.P. 488
Halifax (Nouvelle-Écosse) B3J 2R8
(902) 424-5868
www.gov.ns.ca/health/

Nouveau-Brunswick
Ministère de la Santé et du Mieux-être
B.P. 5100
Frédéricton (Nouveau-Brunswick) E3B 5G8
(506) 453-2536
www.gnb.ca/HW-SM/sm/

Québec
Ministère de la Santé et des Services Sociaux
1075, chemin Sainte-Foy, r.-c
Québec (Québec) G1S 2M1
1-800-707-3380
www.msss.gouv.qc.ca/
www.ramq.gouv.qc.ca/index.htm

Ontario
Ministère de la Santé et des soins
de longue durée
Édifice Hepburn
80, rue Grosvenor, 10e étage
Toronto (Ontario) M7A 2C4
1-800-268-1153
www.gov.on.ca/health/indexf.html

Manitoba
Centre des services à la clientèle
Ministère de la Santé du Manitoba
300, rue Carlton
Winnipeg (Manitoba) R3B 3M9
1-800-392-1207
www.gov.mb.ca/health/index_fr.html

Saskatchewan
Ministère de la Santé de la Saskatchewan
3475, rue Albert
Régina (Saskatchewan) S4S 6X6
1-800-667-7766
www.health.gov.sk.ca/ps_benefits.html

Alberta
Régime d'assurance-santé de l'Alberta
B.P. 1360
Edmonton (Alberta) T5J 2N3
(780) 427-1432 (Edmonton)
www.health.gov.ab.ca/ahcip/

Colombie-Britannique
Ministère des Services de santé
B.P. 9050, Stn Prov Govt
Victoria (Colombie-Britannique) V8W 9E2
1-800-661-4337
www.healthservices.gov.bc.ca/
health@moh.hnet.bc.ca

Yukon
Yukon Health Care Insurance Plan
B.P. 2703
Whitehorse (Yukon) Y1A 2C6
www.hss.gov.yk.ca/hsframe.html

Territoires du Nord-Ouest
Administration des services de santé
Ministère de la Santé et des Services sociaux
Gouvernement des Territoires du Nord-Ouest
Service de sac n° 9
Inuvik (Territoires du Nord-Ouest) X0E 0T0
1-800-661-0830 ou 1-867-777-7400
www.hlthss.gov.nt.ca/programs/benefits.htm

Nunavut
Gouvernement du Nunavut
Ministère de la Santé et des Services sociaux
B.P. 1000, Station 1000
Iqaluit (Nunavut) X0A 0H0
1-867-975-5700
www.gov.nu.ca/hss.htm